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No. 20.

THE OPERATIVE TREATMENT OF HÆMORRHOIDS.

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Hæmorrhoids, or piles, are vascular tumours situated within the ano-rectal canal (internal piles) and sometimes extending a short distance beyond the anal margin beneath the skin (external piles). They are composed of masses of plexiform varicose veins associated with small arterial trunks and embedded in a framework of loose hyperplastic connective tissue. Each pile is in its origin a distinct tumour, but they exhibit a tendency to coalesce into composite masses. Piles are developed from the internal hæmorrhoidal plexus of veins, which empties itself in part through the inferior and middle hæmorrhoidal veins into the systemic circulation, but chiefly through a series of anal veins and then by way of the superior hæmorrhoidal veins into the portal system. The veins of the portal system contain no valves, or only rudimentary valves.

Special Anatomy.

The descriptive anatomy of the ano-rectal canal is not yet quite satisfactory in its details and a somewhat unsettled nomenclature has made descriptions confusing and, at times, irreconcileable. But a general view of the development and anatomy of the part, sufficient for present purposes, can be given here. The canal is formed by the fusion of the hinder portion of the primitive gut with an invagination of the epiblast called the proctodæum. The proctodæum is at first separated from the hind gut by a wall of tissue called the anal plate. This partition melts away about the fourth week of foetal life, whereby a single tube is formed. The part developed from the proctodæum is lined with squamous epithelium and is known as the perineal portion of the ano-rectal tube. The part developed from the hind gut is lined with columnar epithelium and is known as the rectal portion of the tube. This part is also sometimes referred to as the anal portion of the rectal tube. The perineal portion of the ano-rectal canal, lined with squamous epithelium, is described by some as mucous membrane and by others as modified skin. The submucosa of the perineal portion partakes of some of the characteristics of subcutaneous tissue, being soft and loose, not strong and dense like the submucosa of the gut. Some anatomists describe the internal sphincter muscle as merely a development of the circular muscular coat of the end of the bowel, but, according to Arthur Keith,¹ both the ring sphincters of the anus originate from the proctodæum and not as part of the musculature of the gut. The internal sphincter encloses circumferentially the submucosa of the perineal portion of the anal canal. The anal margin is distinctly marked by the "white line of Hilton" and this corresponds to the line of demarcation between the internal and the external sphincter. The external sphincter, therefore, lies beneath the skin just beyond the anal margin. Just within the

anal margin the lining membrane is puckered in the closed condition of the passage. By Arthur Keith¹ these folds are identified as the "columns of Morgagni," but by no other anatomist as far as I am aware. This portion of the canal varies in length in different individuals, but usually occupies from one to two cm.. The folds fade away proximally into a smoother ring of mucous membrane (or modified skin), lying on a loose connective tissue bed and encircled by the internal sphincter. This is the narrowest part of the canal, forming the throat of a double-ended funnel. It is commonly known as the pecten (*pecten*, a comb), but some anatomists include also the corrugated part higher up in the pecten. The higher part would then correspond with the tines of the comb. The canal proximal to this narrow ring is lined with columnar epithelium. The meeting place of the squamous epithelium and the columnar epithelium constitutes an irregular serrated line, where the two forms interdigitate. It marks the site of the anal plate. There are in some individuals a number (frequently eight) of small papillæ on the pecten, sometimes on the tips of the serrations, resembling polypoid excrescences. They contain nerve elements with dendritic ganglion cells and it has been conjectured by B. B. Stroud, who described and figured them,² that they form special sensory organs. These papillæ seem to be subject to pathological conditions signalized by pain (H. Campbell Magarey³). The rectal portion of the canal, forming the distal extremity of the ampulla of the rectum, is of larger

calibre than the pecten and as it approaches the pecten, it is thrown into a series of longitudinal folds, usually seven or eight. Within each of these folds is accommodated a longitudinally situated branch of one of the superior hæmorrhoidal arteries, together with an accompanying anal vein. The folds of mucous membrane are known to anatomists as the *columnæ rectales* and are



Figure 1.
Ano-rectal canal, somewhat diagrammatic, after Sobotta. "A": Columns of Morgagni. "B": Anal valves. The pecten is the part just below and adjacent to the valves. The transverse fold higher up is Houston's valve.

usually referred to as the columns of Morgagni. The veins lying beneath the mucous

¹ *Annals of Surgery*, 1896, Vol. XXIV., July, p. 1.

² *British Medical Journal*, 1911, Vol. II., July, p. 71.

membrane in this region are numerous, tortuous and communicate freely; they form the chief part of the internal haemorrhoidal plexus which takes its beginning in the perineal portion of the canal. The anal veins passing up in the columns of Morgagni present normally near the pecten sacculations or ampullae up to the size of a small pea; these are believed, with much probability, to be common starting points of piles. The intervals between the columns of Morgagni form caudally a series of little pouches, known as the rectal sinuses (*sacculi horneri*), placed radially in the rectal wall just proximal to the pecten. The depth of the individual depressions varies considerably and in some cases there is no pouch at all. A fold of membrane from the serrated line of the pecten joins the bases of some of the columns of Morgagni and these folds are known as anal valves. In some cases two large dentations join, producing lared valves behind which is formed a large pocket with several indentations or *sacculi horneri*.⁴ These, and perhaps also the smaller ones, appear to be those referred to as Ball's valves. The tearing of a valve by hard scybala, or, as I have also known done, by the clumsily introduced nozzle of an enema syringe, is a cause (or the cause) of fissure and the "septinal pile" of a fissure is said to be formed by the edematous and inflamed base of a column of Morgagni. Developmentally, the anal valves appear to be relics of the anal plate.

Both the anus and the neck of the bladder trace their nerve supply to the fourth sacral nerve, a circumstance which makes it easy to explain the well-known sympathy between the two.

The Production of Haemorrhoids and its Complications.

It is easy to see that the long-continued presence of a mass of firm feces in the rectal ampulla exerts pressure on the anal veins and causes distension and chronic congestion of the whole venous system near the pecten. The influence of chronic constipation on the production of haemorrhoids is thus explained, as also the influence of any other conditions causing fullness of the venous plexus in that situation. It is easy also to understand that internal haemorrhoids are likely to be the first formed. While internal and covered only by relatively delicate mucous membrane, they are also more likely to bleed. Frequently protruded piles acquire gradually a thicker and firmer covering and bleed less, though their size is larger. As they grow larger, they are more likely to be nipped by the sphincter and prevented from retracting within the anus. If this occurs and is not immediately relieved, the compression of the sphincter produces exactly the same set of conditions and results as are seen in a paraphimosis, that is, there is a condition of strangulation produced. The circulation is impeded and serum accumulates in the tissues, forming a solid swelling. This constitutes an "attack of the piles." The tumour becomes very painful, but after a few days resolution occurs, the mass becomes smaller and at length is able to retract into the bowel. But at times the strangulation is more severe and gangrene and sloughing occur. In attacks of the more severe kind there is a secondary inflammation and more

wide-spread exudation with very severe pain. In many cases of piles of long standing, after there have been repeated attacks of strangulation, there is permanent prolapse of the mass through the sphincter. Prolapsed piles are not the same as external piles. They are prolapsed internal piles. There is another kind of "attack of the piles" in which a phlebitis occurs with formation of an inflamed thrombus. The immediate treatment of such a case is a free incision through the inflamed part under anesthesia. Sometimes it is best to operate more radically.

Advisability of Operation.

But what about the general question of operation on haemorrhoids? All cases do not require operation. The majority only cause slight inconvenience. When greater trouble is experienced, the question of operation arises and then it becomes necessary to estimate the probable danger, discomforts or disabilities attaching thereto and also to consider the degree and permanence of cure that may reasonably be expected.

No operation of any sort is entirely free from danger nor entirely avoids discomfort. The death-rate from haemorrhoid operations is exceedingly small, too small to estimate numerically. Nevertheless death is not unknown.

The question of post-operative pain and disability hinges very largely on the method of operation employed and on the operator; this will be discussed at length in what follows.

As to the prospect of complete cure, I think we can say that this may reasonably be expected in every case when the operation—of whatever type—is properly done. Even the worst method will procure good end results, though not so surely, nor so comfortably, as the better methods.

As to permanence, it must be noted that vessels that become varicose and produce piles do not assume a haemorrhoidal condition all at once and the same time. There are as many potential pile-formers as there are columns of Morgagni, usually seven or eight. If the patient is a young man, though all the piles have been efficiently removed, more may grow in later years. But to a middle-aged man the question of recurrence does not arise when the operation is efficiently performed. In the latter case recurrence is a result of poor operating. I have seen both kinds of recurrence. The possibility of recurrence from the former cause should not deter from operation on a young man, but the surgeon, in his own interest, should explain the position.

There is, indeed, so little uncertainty about the results of operation that I am sure the great majority of medical men will agree that operation is to be recommended in every case of really troublesome haemorrhoids.

Having agreed that satisfactory end results may be reached by differing methods, which method shall we prefer? Operative measures may be classed, conventionally, under five headings: (1) crushing, (2) longitudinal excision (called the suture method in some hospitals), (3) ring excision (commonly known as the Whitehead method and often referred to in America as the American operation), (4) ligature, (5) clamp and cautery. But there are many ways of carrying out all these methods; success depends

⁴ B. B. Stroud, *loc. cit.*

greatly on the smaller details. In the last analysis there are really as many methods as there are operators and the success of any operation or series of operations depends ultimately on skill and knowledge, on the personal factor of the individual operator, and on the relative difficulty of the problem in each patient, not on the name of the operation. This applies, of course, not only to operations on haemorrhoids, but to every operation of surgery.

Crushing.

Crushing was introduced by George Pollock, of St. George's Hospital, London, who described it in the *Lancet*.⁵ Crushing consists in the compression of the pile at its base between the jaws of a screw clamp so powerful as to disorganize its structure completely and to kill it outright. Excess of tissue is then cut away. Great emphasis was laid by Pollock and later on in correspondence by Benham, his collaborator, on the small amount of after pain following this procedure, as compared with the ligature operation, which he had previously practised. I am quite sure that Pollock did succeed in producing a more humane operation than the method of ligature and that Benham had good grounds for asking readers in one of his letters "in the cause of humanity to give the operation by crushing a fair trial, as the convalescence of the patient is speedy and unattended with any pain or inconvenience." I have never seen this operation performed. But Pollock himself admits that his crushing could not always be relied upon to stop bleeding, which he dealt with, when it occurred, by ligature of bleeding points. In the text books describing the operation, bleeding is also referred to and it is recommended that it be dealt with either by ligature, as Pollock advised, or by searing with the cautery. This reduces the crushing operation, as regards large piles, to the position of a special modification either of the ligature or of the clamp and cautery method. Crushing does not seem to be much used at the present day.

Longitudinal Excision.

Longitudinal excision or the so-called "suture" operation, presents several varieties. Coates's operation is done with a special clamp; sutures are passed behind the clamp, the pile is cut off, the clamp removed and the sutures tied. Another variety is described by A. B. Mitchell.⁶ In this an ordinary straight pedicle clamp is used, the pile is cut off and a continuous whipped suture placed tightly on the stump distal to the clamp before the clamp is removed. A specially tied loop is placed at the upper end to secure the chief vessels. This is described as Earle's operation by Swinford Edwards in Burghard's "Manual of Operative Surgery." A third variety is described by Thelwall Thomas, of Liverpool.⁷ He recommends Doyen's broad ligament clamp, small size. The suture is threaded with a needle at each end and after the pile is cut off, the stump is sutured distal to the clamp with needles crossing from either side and a reef knot is tied at each crossing. Thelwall Thomas in his article says that the treatment of haemorrhoids by tying strings

around them to produce separation by sloughing, leaving areas of mucous membrane to granulate or ulcerate and cauterizing with subsequent separation of eschar by ulceration, appears to him to be "contrary to the spirit of modern surgery." For all that, he insists that the sutures he puts in must be tied tightly together, which must mean the establishment of exactly the same condition—strangulation of the suture line with secondary healing. At the same time, he asserts that he operates by "a method designed to bring about healing by first intention." This operation is referred to in most text books as Thelwall Thomas's operation, but the identical operation is described as Robert Jones's by Swinford Edwards in Burghard's "Manual." I note that Thelwall Thomas at the close of his article remarks that "Mr. Robert Jones, of this city, in the *Provincial Medical Journal*, August 1, 1893, advocates a method of clamp and suture on the same lines as I have described." The operation just described is said by Thelwall Thomas to be best suited for internal haemorrhoids; he states that it is not well suited for large external piles. It is claimed, no doubt with truth, that there is comparatively little after pain and that it gives good results. The method has a number of followers at the present day. I have never used it, but I am ready to believe that within the limits set by Thelwall Thomas it is a very good operation, though I am wholly sceptical as to the claim that it is likely to be followed by healing by first intention. Tight haemostatic suturing forbids such a result in every other part of the body.

Ring Excision or Whitehead's Operation.

The operation of ring excision involves removal by dissection of a complete tube of anal mucous membrane together with the contained haemorrhoids. The edge of the rectal mucous membrane is then sutured to the edge of the skin at the ano-cutaneous margin. The operation was first described by Walter Whitehead, of Manchester.⁸ In 1887 he published⁹ a report of 300 cases. Another ring excision procedure was described by A. H. Vernon¹⁰ and another very similar to Vernon's by Don.¹¹ They are both similar in principle to an operation described as Vercesco's method in Binney's "Operative Surgery,"¹² which is said to have been published in 1902. These operations all seem superior to Whitehead's technique, but they are probably seldom done, so a ring excision practically always means Whitehead's. Stanmore Bishop, also of Manchester, strongly advocated Whitehead's operation.¹³ In a later article¹⁴ he stated that he considered it essential to success that not merely the mucous membrane but the tough submucosa of the rectal tube should be brought down to the skin. This is not mentioned in Whitehead's or other descriptions, nor, in Stanmore Bishop's first article. Yet Bishop says that failure to do it is likely to produce ring ulcer and subsequent stricture. The *British Medical Journal* in January, February, March and April, 1910, contained a raging controversy on the

⁵ *Lancet*, 1880, Vol. II., July 3, p. 1.

⁶ *British Medical Journal*, 1903, Vol. I., February 20, p. 482.

⁷ *British Medical Journal*, 1898, Vol. II., November 26, p. 1008.

⁸ *British Medical Journal*, 1882, Vol. I., February 4, p. 148.

⁹ *British Medical Journal*, 1887, Vol. I., February 26, p. 449.

¹⁰ *British Medical Journal*, 1907, Vol. II., October 5, p. 903.

¹¹ *British Medical Journal*, 1912, Vol. II., October 5, p. 861.

¹² Seventh Edition, p. 515.

¹³ *British Medical Journal*, 1909, Vol. II., October 30, p. 1275.

¹⁴ *British Medical Journal*, 1911, Vol. I., May 6, p. 1033.

subject of Whitehead's operation. Letters from Stanmore Bishop and F. C. Wallis had nothing but praise for it; they used it exclusively. Nevertheless, Wallis regarded good nursing as the "keynote of success" and remarked that careful nursing is necessary to avoid post-operative infective proctitis with chronic ulceration. On the other side, Harrison Cripps wrote that he had seen quite a number of cases of annular stricture following the operation; he regarded it as "the worst operation that has ever been introduced for the cure of the malady." A letter then appeared from W. Ernest Miles, who agreed with Cripps that "Whitehead's is the worst operation ever devised for the cure of haemorrhoids." He had in his own practice seen 37 cases of bad results following the operation, of which 22 had anal stenosis, 9 had extroversion of mucous membrane and 6 had blind internal fistula; he did not agree with Wallis that however well the operation is conducted, the ultimate result will be made or marred by the nursing. There were many other letters, but these were samples from leading specialists. My own personal experience of Whitehead's operation is *nil*, but after comparing and weighing the accumulated experience of others as they have given it to us, I am satisfied that Harrison Cripps and Miles were on firm ground when they condemned it as the worst operation ever introduced for the cure of haemorrhoids.

Ligature.

The ligature operation has been for many years very widely used by British surgeons and it is probably much more used than any other. The technique commonly employed is attributed to Salmon. I am not sure of the date, but it is probably from 70 to 80 years old. The haemorrhoid is detached from the underlying sphincter and a pedicle is made containing the vessels coming down from the rectum. Then a silk ligature is tied as high as possible on the pedicle. The excess of strangulated tissue is sometimes cut off, sometimes not. The strangulated part dies and comes away as a slough with the ligature. There can be no question that the ligature operation is an effectual means of curing haemorrhoids. But it is not a humane method. It is followed by a prolonged period of severe pain that amounts, in many patients, to horrible torture. I have known surgeons who not only practised this operation, but refused morphine to the victims afterwards. Moreover, a relatively high proportion of the patients are unable to pass urine and require catheterization, which is not always an innocuous proceeding.

I have for a good many years ceased to use the method. A surgeon who actually practises the operation, should be a credible witness free from bias against it. W. Ernest Miles, of London, in an article entitled "Observations upon Internal Piles"¹⁵ claims to have performed over 5,000 ligature operations on haemorrhoids. While his preference is for the ligature operation, he says that it does not appear to matter much which particular method is adopted, provided it is done efficiently. We may take it, however, that

this tolerant view hardly includes the Whitehead operation (see above). This is what he says about pain (ligature operation):—

An operation for internal piles is attended by a great deal of after pain. As soon as the patient begins to recover from the anaesthetic, he will be conscious of pain in the anal region. This pain increases in severity during the first six hours, after which it gradually subsides and practically disappears at the end of 20 hours. If the patient becomes very restless and loses control of himself during the first six hours, the pain may be kept up indefinitely. It is important, therefore, that steps be taken to relieve pain as soon as possible. For this purpose a hypodermic injection of half a grain of morphine should be administered as soon as the patient had returned to bed. A sedative mixture should then be given at definite intervals with the object of helping to relieve pain and of preventing the bowels from acting.

The mixture Miles recommends contains 0.6 mils, or 10 minims, of tincture of opium and is given every four hours for the first 24 hours, every six hours during the second 24 hours, every eight hours during the third and fourth 24 hours. On the night of the fourth day he gives a strong aperient. Note well that Miles administers as a routine no less than 30 milligrammes (gr. $\frac{1}{2}$) of morphine hypodermically immediately after the operation and in addition to this he gives, within the first 24 hours, nearly four mils (3 i.) of tincture of opium by mouth!

As to micturition, Miles says:—

After an operation for piles spasm of the sphincter muscle of the urinary bladder persists for about 20 hours. During this period, therefore, the patient should not attempt to pass urine; if he does, he will probably not be able to do so and the straining to void urine will prolong the period of spasm, necessitating eventually the use of the catheter, which should be avoided if possible.

Miles ought to be authoritative enough for anyone and he is here describing the operation that he himself practises. The fact will appear that in substance, though not in form, Miles is here contributing a most eloquent argument for the adoption of the clamp and cautery operation.

It will be profitable to discuss at this point the cause of the pain after the ligature operation. If the experiment be made of tying a ligature round the base of one of the little fibro-papillomas of the skin that are so frequently met with on the back or on the inner aspect of the thighs, it will be noticed to become dark, swollen, oedematous and very painful. Then it dies, the pain ceases and it sloughs. The pain of an "attack of the piles" when the protruding pile is nipped by the sphincter and strangulated shows that the haemorrhoid itself can in a similar way become the seat of pain when tightly gripped; the ligature is to all intents and purposes the same as a much intensified sphincter grip. The pain represents the death agony due to the strangulation. The included part is not killed immediately and the pain goes on until it dies. Then relief comes, as it comes to an inflamed appendix when it dies. The same thing is seen in a dying tooth-pulp. The advantage of the crushing operation over the ligature, in this respect, lies in its power to kill the included tissue in a few seconds. The cautery kills likewise, killing outright, similarly to a fourth degree

¹⁵ *Surgery, Gynaecology and Obstetrics*, 1919, Vol. XXIX., November, p. 497.

burn of the skin, which is painless. The lesser degrees of burning are painful, because they do not kill, or do not kill immediately.

Clamp and Cautery.

The cautery is said to have been employed in the treatment of haemorrhoids by Hippocrates. I am not intent on tracing the history of the modern operation by clamp and cautery in foreign countries, but, according to Henry Smith,¹⁶ it appears to have been first advocated in the British Isles by a Mr. Cusack, of Dublin. It was afterwards adopted by Henry Smith, who was Professor of Surgery at King's College, London, and by others. Smith developed, improved and popularized the operation. Since his time other eminent King's College men, such as Watson Cheyne and F. F. Burghard, have greatly influenced surgical practice in the same direction. Indirectly Henry Smith was responsible for the adoption of the same method by Dr. W. J. Mayo, of the now famous Rochester Clinic. Some time ago Dr. Mayo remarked that he adopted it as a result of reading a correspondence on the subject in the *Lancet* a number of years ago. Smith¹⁷ described his latest technique and reviewed his experience. This was followed by a letter from a certain well-known specialist (whose name I need not give), criticizing the operation in a tone reminding one of a tradesman running down another shopkeeper's goods and proclaiming that he had very much better goods to sell in his own shop. Thereupon followed an able letter from F. F. Burghard, supporting Smith in every particular, while the inept critic, who had been very unguarded, found himself pinned on a set of extremely inconvenient dilemmas. The eminent specialist must have had the sense to see that he had "put his foot in it" very badly and was heard from no more. Other interesting letters followed, all confirming the excellency of the method advocated by Smith. This was the correspondence recalled to notice by Mayo.

In the earlier years of my practice I followed the majority and always used the ligature operation, for the same reason that most of us have, because it was the tradition I had inherited from student days. But while the ligature operation had much to recommend it, it still left something to desire. I thought I would test the clamp and cautery method which was by some men so highly commended. Having tried it once, I was immediately struck with the contrast as regards post-operative pain and I thought it worth further trial. I have not done the ligature operation since.

Experience has shown that some ways of performing this operation are better than others. I have digged deep into the subject, I have considered very carefully and critically the recorded experience of many capable men and I have accumulated an experimental knowledge of my own that is worth something. In sum, I have taken every opportunity of getting and keeping my technique to optimum standard and this technique I here set forth and recommend.

A patient who is a reasonably good operative "risk," should not require the several days of gaol

discipline and diet that some surgeons have insisted on. Nor should he be repeatedly purged during the same period. The "lowering" system of pre-operative treatment is traditional in the profession, not only for haemorrhoids, but for other operations. It has nothing in reason to recommend it. A bad "risk" would need much longer preparation than a few days and a good one need not and should not be made physically or mentally ill beforehand. The repeated purgations that some employ may be an effective method of exhausting the bowel in order to induce a purposely prolonged period of post-operative constipation, but this custom of locking up the bowels I have given up after a long trial of the tradition. A moderate dose of castor oil or other mild aperient will not cause an unduly delayed post-operative action of the bowels. Such an aperient should be given and then an enema some four hours or so before the operation.

The patient is anaesthetized with ether. I have had no experience of local or spinal anaesthesia for this operation and therefore am scarcely qualified to pass opinion upon it. But I have dug out some very interesting information as to the pain experienced when no anaesthetic at all is used. A letter was contributed to the *Lancet* before the invention of local anaesthesia, by T. F. Clarke, of Cape Colony.¹⁸ Clarke had done a number of clamp and cautery operations, both with and without anaesthetics. As to the latter class, Clarke wrote as follows: Conscious patients operated on by clamp and cautery "always tell me that the only pain they suffer is when the pile is first secured in the clamp; the cutting and the application of the cautery they do not feel either at the time or when the clamp is removed."

I have always used the lithotomy position. I do not know the reason why some operate with the patient lying on his side or semiprone, but I will not condemn what I have not tried.

Many surgeons lay very great stress on the necessity for very complete dilatation of the anus. I note, however, that Smith recommends that it be done with some caution, as he had seen permanent complete incontinence caused. It has been stated very frequently that thorough stretching of the sphincter diminishes post-operative pain. This is very questionable and I am amongst the sceptics. I agree, however, that a flaccid sphincter tends to lessen the danger of concealed haemorrhage from slipping of a ligature off the pedicle after the ligature operation—an accident I remember seeing in my house-surgeon days—or from other causes. A discussion on the subject of dilatation of the sphincter occurred in the correspondence columns of the *British Medical Journal* in 1911. After a good deal of consideration, it seems to me that dilatation of the anus should be done only to a degree sufficient for a proper view of the diseased area and enough to afford reasonable convenience to the operator, but no more. When the piles are already prolapsed, the sphincter has been already dilated by the tumours to an extent sufficient for all purposes; manual stretching is certainly unnecessary. Miles¹⁹ makes a knife cut through the pecten and

¹⁶ *Lancet*, 1880, Vol. I., March 13, p. 398.

¹⁷ *Lancet*, 1893, Vol. I., March 4, p. 469.

¹⁸ *Lancet*, 1880, Vol. II., October 30, p. 718.

¹⁹ *Loc. cit.*

does not stretch the sphincters at all. He describes the presence of a thin fibrous band beneath the mucous membrane of the pecten and produced, he believes, by chronic congestion. He says that release of this band by section allows easy eversion of the pile-bearing area. This I have not yet studied experimentally.

Having exposed the area, it is carefully examined and the situation of the piles noticed. The edge of the sphincter should also be noted, so that it should not be injured. It will be found that the piles can practically always be grouped into three masses. In many cases the masses are a combination of internal and external haemorrhoids, part of the tumour lying beyond the anal margin, where it is covered by true skin. When part of the mass is thus covered by skin, the skin must not be scorched by heat from the cautery. With a pair of blunt-pointed scissors snip through the skin not far from the anal margin, make the cut crescentic in shape, with the horns of the crescent reaching the ano-cutaneous line and the convexity away from the anus and dissect outwards towards the extremity of the pile, so that the tumour can be lifted up, clamped and cauterized without either pinching or burning the skin. There should never be any skin pinched by the clamp and there should always be enough separation to make it unnecessary. Only the small crescent of skin at the anal margin is lost. When the mass is sufficiently defined, it is grasped by forceps and lifted up. Then the clamp is applied in a direction longitudinal to the bowel, i.e., radial to the centre of the anus. The clamp must include the whole pile or pile group. It must not be allowed to omit any small or incompletely developed pile, or recurrence may take place; it must take hold of the mass at its base, not merely a piece of the most prominent part of the mass. A fault of this kind will also cause recurrence and that probably rather soon. At the same time, care must be taken to include no more than the pile. On no account should any of the sphincter be included. There is no real difficulty in doing all this. I have usually employed either a Smith's or a Langenbeck's pile-clamp, but if my wooden guard or fender is available, any convenient pedicle clamp will do. Doyen's smaller pedicle clamp, recommended as a pile-clamp by Thelwall Thomas, ought to be an excellent form. The clamp is to be applied as tightly as possible, to prevent slipping.

Now comes the question of what cautery to use and how to use it. It has been the custom of some surgeons to cut off the pile with scissors and then to apply the Paquelin cautery to the stump, after which the clamp is released. I do not in the least wish to suggest that very good results may not be obtained under this technique, but I am sure it would be better abandoned. As to the cutting off of the pile with scissors, Smith says that he did this in his earlier operations and in most cases it succeeded well, but from time to time haemorrhage occurred subsequently. He found that with thick tumours occasionally part of the centre might retract and escape the cautery. He therefore abandoned the use of scissors and sawed through the tumour with the cautery (not Paquelin's), starting at a dull red heat and after this change of technique he had no post-operative bleeding. As to the Paquelin cautery, there

are two disadvantages. The first is that it occasionally refuses to work when wanted. The second is more serious. It is not realized by every surgeon that cooking of the tissues to some depth is more important than merely burning them; indeed, it is essential. The Paquelin is not easy to keep at a regulated temperature. It see-saws between too hot and too cold; at one minute it is bright red, at another dull. Now the tissue that has been directly attacked by the red cautery is charred, but it is liable to bleed like tissue cut with a knife, perhaps not immediately, but after the operation is over. The point must be emphasized that the tissue beneath must be cooked to some depth, coagulating the protein by the boiling of the water present and partially desiccating the surface. For such a purpose as this the simple form of cautery is a much surer implement. The cutting off of the pile and the use of the Paquelin, if made the standard of practice, would be sure, in time, to get the clamp and cautery operation a bad name bred by the technique used. The history of the operation shows that it won its way into confidence on the old-fashioned type of cautery and it is a departure from well-tried standard practice to use the Paquelin. A departure is right and proper when it improves results. I have seen the Paquelin used a good many times, but I have no knowledge of any improved results.

Personally, I use no other cautery for the operation but a common soldering iron of large size, at least one for each pile-mass and two should be ready for large ones. It is heated to a dull red heat and, though from its mass it contains a large quantity of heat, it is not at too high a temperature. The outside of the cautery has subsided to a black heat before cauterization actually begins. The pile is not cut off, but burned off and the base cooked through and through to a leathery consistency. An important part is the cephalic end of the pile where a branch of the superior haemorrhoidal artery, the arterial supply to the pile, comes in; this part should be slowly cooked and shrunk up rather than separated off by the cautery. When the cauterization has been completed, a little time is left for cooling down and then the clamp is removed and the leathery, cooked stump is allowed to drop back. Then it is carefully inspected to see if any bleeding occurs; if any is seen, the bleeding part is drawn up by forceps, clamped again and separately cauterized.

The clamp and cautery are thus in turn applied to each of the three masses of piles. It is nearly always possible to finish the operation with three clamping.

If there has been some dissection of skin off a portion of the pile-mass, there may be some oozing near the anal margin. The best way to stop this is to pass a few catgut sutures beneath with a curved needle and tie. This is done at the close of the operation. I never apply iodoform. Some surgeons insert a dressed tube through the anus into the rectum. This practice should be reserved, as Binnie remarks, for personal enemies and malefactors.

There is a traditional custom—it dies hard—of inserting a morphine suppository into the rectum at the close of an operation for haemorrhoids. This is a relic of the old notion that this drug had a local

anæsthetic action. The theory is long dead, but the practice lingers on by mere force of inertia. Medicine and surgery contain many such relics. Is it not time that this old relic disappeared and a hypodermic injection be substituted? I always have 15 milligrammes or $\frac{1}{4}$ grain of morphine injected hypodermically before the patient becomes conscious.

I may say here that it takes a long time to heat a soldering iron over a gas-ring. A flare lamp or primus will bring it up quicker.

In any cauterization operation involving the employment of the soldering iron, there is a considerable output of radiant heat from the metallic mass which would scorch the skin around, if it were exposed. In addition, the mass is heavy and it must not be allowed to slip off its objective and glance over the surface of the clamp into the skin. At first I used to protect the skin with a layer of damp pads to prevent scorching, but later on I had a wooden fender or guard made which has been found a most useful contrivance. It consists of two broad concave wooden glades hinged together at one end and narrowed at the handle end. It is slipped behind the closed clamp, between the clamp and the skin and then shut and

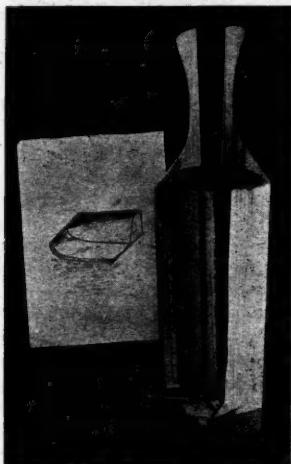


Figure II.

Fender for use in the cauterization operation for hemorrhoids. The blades are concave pieces of wood hinged together at one end. The instrument is applied proximal to the clamp. When closed behind the clamp there is a narrow slit-like opening to accommodate the thickness of the pedicle. When in position it prevents scorching of the skin in the cauterization. On one handle has been laid a measure showing inches and centimetres, to indicate size; beside the instrument is a drawing showing shape at one end. The end portion would be improved if a little more substantial, giving a better bed for the hinge screws.

held behind it. It acts as protection to the skin against radiation and, being concave towards the clamp, if the soldering iron were to slip, it would only glance on to the concave surface of the wooden fender and do no damage. I can thoroughly recommend this addition to the technique. In the absence of a specially made fender, two forearm splints can easily be adapted to the purpose.

If there has not been any burning or scorching of skin there will be little or no post-operative pain. If the patient has much pain, it is not due to the cauterization of the hemorrhoids, but to errors of technique, by which some skin has been injured by burns of the first, second or third degree. As I have already pointed out, there is no pain in a fourth-degree burn, which has completely killed the tissue; the pile has been burned to this degree. This is the secret of the comparative painlessness of the clamp and cauterization operation as compared with the ligature method.

Retention of urine is a very rare event after the cauterization operation. I dare say I have had a case, but I do not remember it. About two days after the operation there is sometimes some swelling of the part with temporary eversion of the anus and accompanied by discomfort rather than pain. The patient may imagine the piles have returned, but there is no need for alarm. It always subsides and the patient is usually well enough to get up in a week and leave the hospital not later than the tenth day. The parts are bathed and kept clean. An aperient is given on the day following the operation. Experience shows that this is much more comfortable for the patient than the older custom of locking up the bowels until the fifth day. Low diet is not required. If the patient feels well, is well in every respect except for his wound, and feels hungry, I cannot imagine any valid reason why he should be kept on slop diet and made miserable. It is only a bad old custom.

Strangulated piles ought to be operated on at once. I know some surgeons have considered operation contra-indicated in such cases, but I take quite an opposite view and I think them urgent for operation. That it is a standing rule for my cases at the Sydney Hospital. The patient is admitted and operated on the same day as he presents himself, just as is done with strangulated hernia or acute appendicitis. It saves him at once from much misery, it economizes hospital time and the patient, disabled from work in any case, is both relieved of pain or discomfort and cured of his disease, so that the time is profitably spent instead of wasted. In a certain proportion of cases of strangulated piles they go on to partial or complete gangrene and sloughing. If possible, it is desirable to operate before this occurs. This is an additional reason for operating forthwith. Sloughing sometimes causes severe inflammatory reaction beyond the pile with acute agony and, occasionally, really severe illness. In these cases much of the pain is not intrinsic in the pile, but is more or less extrinsic and proceeds from the surrounding inflammation. The same relief from pain that is obtained from operation on a merely strangulated pile cannot then be expected, though it may relieve it to some extent. I think every case of this kind should be separately considered on its merits and I would not lay down a rule, but in most of them I would prefer to operate. It would be unlikely to make the patient worse and it would more often relieve. It might be argued—and it is argued—that interference during inflammation involves greater risk of septicæmia. If this be true, we ought to find much the same sort of risk in operating on inflamed or gangrenous appendices. The appendix operation is analogous in its conditions, severe infection, thrombosed veins and all complete. But how often does the mere operation by its disturbing influence produce pylephlebitis? In the case of gangrenous hemorrhoids it is the virulence of infection that counts for most. I doubt if operation causes much more disturbance than is brought about by defaecation under such circumstances. And as for septicæmia, the only case of death following operation for piles that I know of occurred in the practice of a very competent surgeon of my acquaintance after he had operated by the ligature method on an ordinary case of hemorrhoids. The

cause of death was pneumonia; it is not impossible that it was an inhalation pneumonia, due rather to the anaesthesia than to the actual operation.

After Results of Various Operative Methods.

I have now stated my own views and described the methods of treatment that commend themselves to me. But I have not quite finished. I direct attention now to an impressive paper entitled "The After Results of the Operative Treatment of Haemorrhoids" by H. Graeme Anderson,²⁰ who therein analysed 300 cases of haemorrhoids treated by operation at St. Mark's Hospital, where he was house surgeon. Of these, 150 were operated on by ligature, 100 by Whitehead's excision and 50 by clamp and cautery. An abstract is given hereunder:

(1) *Post-Operative Pain.*

Operation.	Severe Pain.	Moderate Pain.	Little Pain.
	Per cent.	Per cent.	Per cent.
Clamp and Cautery..	0 ..	30 ..	70 ..
Ligature	10 ..	57 ..	33 ..
Whitehead	18 ..	56 ..	28 ..

The amount of sphincter stretching seemed to bear little relation to the amount of pain experienced. In the clamp and cautery operation, pain was more severe if anal skin was included in the clamp and cauterized, or in the ligature operation when some fibres of the sphincter were included, or when submucous tissues were unduly adherent to the sphincter.

(2) *Catheter After Operation.*—After ligature, 10% required catheter; after Whitehead, 6%; after clamp and cautery, none.

(3) *Return of Sphincteric Control.*—In clamp and cautery cases control returned on the average on the sixth day after operation. In ligature cases on tenth day, longest fourteenth day. In Whitehead cases on twelfth day, longest twenty-fourth day.

(4) *Contraction of Anal Canal.*—After clamp and cautery, no cases of contraction. After ligature in 55% there was no tendency to contraction, in 40% there was slight contraction, in 5% more marked contraction, which required instrumental dilatation up to six weeks after the operation. After Whitehead's 36 showed no tendency to contraction; in these there was very little retraction of mucous membrane; in 56 there was slight contraction easily overcome by digital dilatation; in these there was retraction of mucous membrane to the extent of about 1.2 cm.; in eight there was decided contraction; four of these were due to sepsis and ulceration following the operation; these were cases of sloughing and gangrenous prolapsed piles and the mucous membrane retracted to the extent of 2.5 cm. Of these four, two patients had secondary haemorrhage. The other four patients had retraction of from 1.2 to 1.8 cm. Stenosis was finally overcome by instrumental dilatation, but in all of them there could afterwards be felt a fine fibrous ring encircling the anal canal.

(5) *Development of Tags.*—In 50% of the clamp and cautery, in 60% of the ligature and in 70% of the Whitehead cases there was practically no formation of tags. In 44% of clamp and cautery, in 45% of ligature and in 25% of Whitehead cases there was decided tag formation. In 6% of the clamp and cautery, in 15% of the ligature and 5% of the Whitehead cases there developed rather large tags, which

were removed under local anaesthesia during the third week after operation.

(6) *Hæmorrhage.*—Eight cases of hæmorrhage occurred. (a) In the clamp and cautery cases there was one of accidental hæmorrhage due to carelessness of a nurse. No cases of recurrent or secondary hæmorrhage followed the clamp and cautery operation. (b) After the Whitehead there was no case of recurrent hæmorrhage, but two cases of secondary hæmorrhage occurred, one on the sixth day and one on the eighth day. These were in the two cases of gangrenous prolapsed piles in which sepsis occurred; one was treated by packing, the other required an anaesthetic and the use of the cautery. (c) After the ligature operation there was one case of accidental hæmorrhage caused by the patient interfering with his dressing; there were two cases of secondary hæmorrhage, one on the ninth day and one on the tenth day. Both patients were given general anaesthetics and in neither was there sepsis or ulceration. In one case an artery required ligation and in the other there was venous oozing arrested by packing.

(7) *Abscess, Fistula and Ulceration.*—None of these complications ensued after clamp and cautery. After ligature in one case there developed a small perineal abscess; in two there developed chronically infective ulceration, treated variously and arrested after about a year, but this left fibrous stenosis of rectum. After one Whitehead operation a small fistula developed, while four were complicated by sepsis and three of these occurred in cases of gangrenous piles. The clamp and cautery operation seemed to be the least followed by sepsis; the wound is in the long axis of the bowel and there is no tension and little reaction.

(8) *Recurrences.*—None was seen within 18 months. In the out-patient department there was seen one recurrence after ligature 18 years before and one after operation by suture (longitudinal excision) two years before.

(9) *Healing of the Wound.*—Healing was obviously best after clamp and cautery, producing linear scars and no stenosis. After ligature the wounds assumed a triangular shape, a little contraction was common, but it was easily dilatable. After Whitehead's in 50% the sutures gave way on the fourth day, before the bowels were moved. In the other 50% the sutures broke down when the bowels acted the day following. Not one of the Whitehead cases healed by first intention.

Conclusion.

My object in presenting this review of the operative treatment of haemorrhoids is to induce surgeons who preserve an open mind, but who may be personally unacquainted with the clamp and cautery method, to give it a fair trial. This means the employment of a technique that embodies the accumulated experience of practical exponents.

I conclude with the following summary of the advantages of the clamp and cautery operation when carried out with reasonable care and according to the technique I have recommended.

(1) It is bloodless and therefore pre-eminently suitable for anaemic and debilitated patients.

(2) It can be carried out in a private house quite

easily and safely and with far more convenience than any of the other operations.

(3) Notwithstanding statements to the contrary, it can be efficiently used for any kind or degree of haemorrhoids. Its efficiency is 100%.

(4) It is certainly the best method of dealing with strangulated or with gangrenous and sloughing haemorrhoids.

(5) Post-operative pain is relatively slight and often quite absent.

(6) Reflex post-operative retention of urine is rare, the symptom being probably directly proportional to the degree of post-operative pain.

(7) Post-operative haemorrhage, whether reactionary or secondary, is extremely rare.

(8) Convalescence is shorter than after the ligation or other operations. It therefore economizes hospital time and allows the patient to return to work sooner.

(9) It occasions least post-operative anxiety and least requires highly trained nursing. Post-operative attention by way of digital stretching or passage of bougies is least often, and very seldom, required. It is therefore advantageous for cases in which the surgeon may be unable to see the patient again afterwards.

(10) While anal stricture has been reported after every type of operation for piles, such cases are much more seldom after the clamp and cautery than after the ligation or the Whitehead operation.

(11) Reports of recurrences are, relatively, extremely few and hard to find.

Reports of Cases.

ULNAR PARALYSIS FOLLOWING INDIRECT VIOLENCE THROUGH THE FEET.

By Kevin Byrne, M.B., Ch.M. (Syd.),
Lakemba, New South Wales.

At 4 p.m. on September 14, 1920, a loaded passenger lift in the Queen Victoria Markets, Sydney, carried away from the second floor to the basement. All the passengers remained in the standing position and received through their feet the force of impact of the lift with basement floor.

At 6.30 p.m. one of them, Mrs. J.W., aged 30, consulted me for "a twisted neck" and "deadness of the left arm."

Examination.—Patient is a well-built woman who states that she has never consulted a doctor in her life. She is muscularly strong, an oarswoman and athlete, by occupation a manufacturing jeweller. She is not hysterical and is of a sensible type. She has a marked torticollis. Her head is turned towards the left side. There is severe pain on passive movement and marked tenderness on slight pressure over the seventh cervical and first dorsal vertebrae. There are no bruises or other external marks of violence.

A definite ulnar paralysis of text-book exactness is noted in the left forearm.

Dr. J. G. Edwards examined her spine with X-rays and reported: "An abnormally long transverse process on the right side of cervical rib 7. There is some lateral curvature of the dorsal spine with the 3rd dorsal vertebra as pivot, but we are unable to state whether this is due to injury or not."

September 15, 1920.—Menstruation occurred a fortnight before its expected time.

September 18, 1920.—The torticollis is improving.

September 19, 1920.—A severe coccydynia set up which has since improved.

October 8, 1920.—The patient was seen in consultation

with Dr. Purdy, City Health Officer, for the City Council, owners of the lift.

The torticollis has improved, but the ulnar paralysis has improved but slightly.

Her fingers cannot be flexed at the first or extended at the second joints.

Abduction of the thumb can be carried out slightly.

Epicritic sensibility is absent over the little finger, the ulnar half of the ring finger and along the palm and dorsum, corresponding to the parts supplied by ulnar cutaneous branches.

Protopathic and deep sensibility are also upset.

There is occasionally severe tingling. The power of adduction and abduction of the fingers is almost lost.

The patient walks with a peculiar gait, similar to that of one affected with a sore pile. The coccydynia has improved. The median nerve is in no way affected.

The interest of this case lies in the fact that all violence occurred through the feet upwards.

The ulnar nerve arises from the last cervical and first dorsal roots and is associated with the lowest part of the cervical enlargement of the cord. The patient was tender over the seventh cervical and first dorsal vertebrae, at which site there was no bony lesion visible by X-rays.

Reviews.

THE NURSE IN SMALL HOSPITALS.

Miss Félicie Norton, of the Royal Hospital, Portsmouth, has written an agreeable and useful little book for the use of sisters,¹ and staff-nurses who aspire to be sisters, in small hospitals. She explains clearly why the conditions in small hospitals are different from those found in the larger. In the cottage hospital there is usually no resident medical officer, so that more responsibility attaches to the matron or sister; public opinion among the nurses is perhaps stronger—may we dare to say more feline?—and each nurse has to learn anew the great old rule of give and take. One appreciates with a little start of surprise what a network of convention still surrounds woman even in this twentieth century; she almost may be said to hug her chains. Miss Norton brings home to the mere man how even the stately sisters whom we reverence in the wards, have to walk ever so warily lest trouble befall them and she gives much excellent advice as to conduct which may help some giddy-pate—if such there be in the nursing profession. But after all she rightly insists that personality is of prime importance in a nurse and it is hard to inculcate personality. Summed up, it all comes around once more to Kipling's "Law, Order, Duty and Restraint; Obedience, Discipline."

SEVEN SPIRITUAL SONGS.

Many doctors have been distinguished in literature—witness Browne, Keats and half a hundred more—but Campion,¹ doctor of "phiscike" of London in Elizabeth's time, is the only one who has made a name in both music and poetry. His glory is not the resounding fame of Keats or Sir Thomas Browne; he has had to be disinterred; yet these songs of his are fresh, tuneful and redolent of that morning England which we associate with Elizabeth. He was the last of the English poets who manfully fought against rhyme, preferring quantitative metre; he was one of the brilliant galaxy of musicians—to wit, Orlando Gibbons, Tallis and many more—whose madrigals formed a morning glory that was to culminate in the noon-tide splendour of Purcell, one of the greatest names in all musical history. It is difficult to believe that at that time England led the world in music and of her leaders Campion was by no means the least. After Purcell came the long night which was only relieved by a ray of light in the later nineteenth century, a ray

¹ The Duties of Sisters in Small Hospitals, by Félicie Norton: 1920. London: Baillière, Tindall & Cox; Crown 8vo, pp. 75. Price, 4s. 6d. net.

¹ Seven Spiritual Songs of Shakespeare's Time; words and music by Thomas Campion; edited by W. A. Draper; music arranged by Wiloughby H. Williams: 1919. Cambridge: The University Press; Royal 8vo, pp. 24. Price, 2s. 6d.

which may yet herald a great dawn. The songs here reviewed are charming and suitable for performance by amateur choruses and quartettes. England had recently been delivered from the peril of the Spanish Armada and they have for us, just freed from a similar peril, a strangely moving appeal.

University Intelligence.

THE UNIVERSITY OF SYDNEY.

A meeting of the Senate of the University of Sydney was held on November 1, 1920, at University Chambers, Phillip Street, Sydney.

It was referred to a committee to consider a report whether it was desirable to raise the fees charged to students at the University.

It was resolved that an Associate Professorship in Physics be established and that Assistant Professor Vonwiller be appointed to the chair from January 1, 1921.

Mr. G. C. Wellish, M.B., Ch.M., was appointed an Honorary Demonstrator in the Department of Anatomy.

A letter was received from the Secretary of the Bureau of the Universities of the British Empire, stating that Professor Sir William Bragg had been compelled to resign his position as a member of the Committee of the Bureau for private reasons. It was resolved to nominate Professor J. T. Wilson, lately Professor of Anatomy in Sydney and now Regius Professor at the University of Cambridge, to fill the vacancy, communications having been received at the University from the majority of the Australian universities agreeing to this proposal. It was further resolved to appoint Professor W. J. Woodhouse, Professor of Greek, as one of the representatives of the University to attend the Congress of Universities of the Empire to be held in July, 1921.

A report from the Faculty of Science recommending the adoption of Amended By-Laws to regulate the curriculum in that Faculty, was adopted.

The amendments include a slight raising of the standard of entrance for admission to the Faculty of Science. In future, candidates for matriculation in the Faculty of Science will be required to pass in three subjects at the higher standard, of which one must be English or mathematics, another a language other than English and the third mathematics or chemistry or physics.

The curriculum has been modified by allowing science students in the second year to take certain arts subjects (French, German, philosophy) as subsidiary subjects, by the addition of anatomy, geography and agricultural chemistry to the science subjects, which may be taken by candidates for the degree; and also by the addition of materia medica and advanced pharmaceutical science and analysis of foods and drugs, these two subjects being taken by pharmacists who desire to proceed to the degree of Bachelor of Science.

Honours at graduation in science are generally in future to be awarded only to such candidates as have devoted four consecutive years to the studies prescribed in the Science Curriculum.

The degree of Master of Surgery was conferred upon Mr. A. Braby, M.B., and Mr. P. J. O'Shea, M.B.

THE RATSEN CASE.

*The Attorney-General moved the second reading of the *Medical Act Amendment Bill* in the Legislative Council of Tasmania on November 2, 1920. In the course of his speech he dealt exclusively with some of the facts concerning the registration of Victor Richard Ratten and with the action of the Government in its endeavour to reach finality in this matter. He stated that he had received a copy of a resolution passed by the Southern Law Society, protesting against the passing of the Bill on the ground that it was contrary to the principles of English law. The Attorney-General stated that it should not be "overlooked that the Bill did not propose to relieve a medical practitioner

of being dealt with if guilty of felony or misdemeanour." He held that the individual would be in the same position as any other offender. The Bill provided that he could not be deregistered on account of any act committed seven years before. He contended that, notwithstanding the fact that the original members of the Medical Court of Examiners who had registered Ratten in 1907 were still resident in Tasmania, no inquiry into the validity of the diploma was instituted until 1916. Even then the inquiry was not very vigorous or thorough, as the matter was still unsettled.

The Honourable F. P. Hart maintained that the Government was asking Parliament to do a wrong thing. The Bill would have the effect of whitewashing a wrong and of getting certain parties out of their difficulties. Ratten should stand up before the public "and clear his diploma." He was sorry the Government had asked Parliament to do a thing which the Chief Justice was not prepared to regard as right. Even if Ratten had cured the greater part of the population of Tasmania of all sorts of disease, they should not support the Bill, because it was not moral. The Government was unable to show that the diploma was a genuine one.

Other members spoke in support of the Bill. The arguments put forward included the statement that Victor Richard Ratten was a skilful practitioner, that his conduct of the Hobart General Hospital had resulted in a marked reduction of mortality and a considerable increase in hospital fees, that it was not fair to require Ratten to disprove the allegation that the diploma in virtue of which he had obtained registration, was a fraudulent one and so on. The Honourable W. M. Williams, O.B.E., stated that he had received a communication from the Harvey Medical College,¹ certifying that Ratten had attended a full course of senior studies and had attained a high standard in a number of subjects at the final examinations. He also read a letter which he stated was a testimonial from one of the greatest surgeons in Tasmania, warmly commending his surgical abilities.

The Honourable C. E. Davies supported the measure because he thought that finality should be reached. He said that as far as he could gather, no formal charge of fraud had been brought against Ratten.

The motion for the second reading was carried by 12 votes to 2. The measure passed through the Committee stage without amendment.

On November 3, 1920, the Bill was read for the third time and was passed.

The Bill will become law if His Excellency the Governor does not withhold the Royal assent. It is useless to discuss this matter at the present juncture. The medical profession should be warned to have nothing to do with a Government which does not hesitate to protect its protégé against the effect of the law, which, finding that the law will take its course, introduces fresh legislation and creates a fresh statutory body to safeguard the position of the protégé and, when the events seemingly move toward a clearing up of the mysteries surrounding the document presented by its protégé for the purposes of registration, goes to the extreme length of passing an unparalleled act of Parliament devised to render it impossible for the Courts to investigate a charge of fraud which had already been instituted.

The Federal Council of the Australian Natives' Association at its annual meeting in Melbourne adopted on November 4, 1920, a resolution providing for the establishment of a bureau of medical research. We understand that the proposal involves an appeal to the Federal Government to co-ordinate medical research throughout the Commonwealth.

We regret to announce that Dr. Richard Kingston Bird, of Natimuk, Victoria, died in Melbourne on November 2, 1920.

¹ This statement is surprising in view of the following facts. The alleged diploma of Victor Richard Ratten bears the signatures, among others, of W. E. Warner and W. G. French. Neither of these individuals were associated with the Harvey Medical College, but both were associated with the Harvey Medical College and Hospital which was incorporated on January 9, 1907, i.e., two months before the date of the alleged diploma, which changed its name in November, 1908, and which ceased to exist in May, 1912.

The Medical Journal of Australia.

SATURDAY, NOVEMBER 13, 1920.

Clinical Teaching.

Earlier in this year we announced the appointment of Mr. T. P. Dunhill, C.M.G., to the newly created position of Assistant Director of the Surgical Unit at Saint Bartholomew's Hospital in London. At Mr. Dunhill's request we refrained from giving an account of the organization of the units, because information concerning many of the details was not then available and some doubt existed as to intentions of the originators of the idea. An article has been published in *The Lancet* of September 18, 1920, in which the writer records the working of the so-called professorial units. It is now possible to discuss the scheme. We are told that some of the details of structure are tentative and experimental. That the unit system has come to stay in the London schools of medicine there is no doubt. It is further probable that many changes and much modification will be introduced before a satisfactory practice is evolved. The experiment is so highly coloured by war experience that its survival in its present form cannot be expected. Unfortunately, a form of slang terminology has been introduced for which there is neither justification nor need. The term team as applied to surgeons, physicians and specialists working together for the common benefit of patients is expressive and unobjectionable. The term professorial unit is also descriptive and useful. We cannot conceive any reason for the introduction of the word "firm" to indicate the group of teachers associated with one another in one of the units.

In five of the medical schools in London the unit system has been introduced. In four there is at present a medical and a surgical unit, while in the fifth (Saint Thomas's Hospital Medical School) the medical unit has not been formed. In each case there is a director, an assistant director, one or more assistants and a resident house physician or surgeon. At the Saint Thomas's Hospital Medical School the assistant is called the pathological assistant, while at the University College Hospital Medical School the

assistant in the medical unit is an expert in neurology and in the surgical unit he is called the pathological-surgical registrar. Some of the members of the units are whole-time officers, while others are half-time or part-time officers. The units exist for the better organization of clinical training of medical students. In the first place, the student receives general elementary instruction in so-called "case taking," in the application of physiological knowledge to clinical practice, in the methods of diagnosis and treatment, in surgical dressing and in work in the operation theatre. This training is expected to prepare the student for the positions of medical clerk or surgical dresser. He has the immeasurable advantage of constant supervision and personal instruction by the members of the unit. In other words, the system involves a departure from the old system of requiring the student to perform certain easy duties by himself, while the actual work of diagnosis and treatment is carried out by the honorary physician or surgeon during his daily visit or in emergency by the house physician or surgeon. It will be noted that in this plan the patient receives greater and more prolonged attention from the expert, while the student is given personal instruction and is taught, instead of having to struggle with difficulties and of having his mistakes corrected at longer or shorter intervals. The professorial units supplement, but do not replace, the physicians and surgeons who work with their house physicians and house surgeons and clerks and dressers. The material for teaching is selected in the new plan and the field of activity extends to the out-patients' departments as well as the wards. It includes the *post mortem* room and the bacteriological laboratory. It would seem as if an attempt were being made in some instances to render the units self-containing. The special work of diagnosis and pathology in the bacteriological and bio-chemical laboratories and in the *post mortem* room is carried out by the members of the units and by the students attached to them, although the assistance of the specialists in the hospital is sought in particular cases. Provision is made for research, although it seems questionable whether valuable research work can be conducted by a small group of clinicians engaged in a concentrated effort to impart serious instruction to several groups of students.

The underlying principle of the unit system is admirable. In London the system has been forced into being before the essential and inevitable changes in medical education have been seriously considered. We hold very strongly that one of the most urgent reforms required in our medical schools is the institution of continued study of medical chemistry and medical physics throughout the whole course. It is usually admitted that the physiological and biological sciences must be taught by experts in medical chemistry, in medical physics and anatomy and biology. We have expressed the opinion on many occasions that these fundamental sciences should be spread over the five years of the curriculum and that from the first to the last year the student should be in the hands of the professors of each of these subjects. On theoretical grounds it appears that the chief defect of the professorial unit system as it exists in London to-day lies in the fact that the units are aiming at being isolated departments, independent of the fundamental departments of the medical schools, those in which the scientific basis of all medical knowledge is taught. If the unit system is applied in Australia, we would urge that it be grafted on a reformed curriculum and secondly that it be modified in such a manner that the closest co-ordination between the departments of the schools is provided. Instead of the clinical units being independent, there should be an arrangement with the professor of medical chemistry, the professor of medical physics and the professor of anatomy, whereby the student attached to the units could be given the same personal tuition in these special subjects in their relation to medical practice as they receive in the more essentially medical subjects from the director and his staff. The time has passed when adequate medical education can be given by mass teaching. The systematic lecture and the remainder of the old-time paraphernalia of large class teaching is doomed because it is impossible to satisfy modern requirements by adapting the teaching to the understanding of the average student. Personal instruction necessitates large staffs of teachers, the recognition of many branches of special study and the close co-ordination between all those engaged in training future medical practi-

tioners. The experiment in London will be watched with close interest to ascertain whether it is worth while to secure personal tuition in a water-tight compartment loosely adjoined to the medical school.

MERCURIAL POISONING IN INDUSTRIES.

Few general practitioners find the study of industrial diseases and industrial poisoning of sufficient interest to claim their serious attention. It is usually felt that the application of knowledge of industrial hygiene does not extend to the sphere of the general practitioner and further that even though this subject is of great importance to the community as a whole, isolated instances of industrial disease or of poisoning by materials employed in the manufactures can be referred to the expert for treatment. This attitude, however, is speculative. No practitioner can foretell when he may be called upon to recognize and treat an industrial disease process or case of industrial poisoning. If he be unprepared, it is unlikely that the full significance of the condition will be appreciated, at all events until much valuable time has been wasted. Moreover, many of the problems of industrial hygiene are merely specific instances of a more or less specialized type of the problems of every-day medical practice. The attention of the general medical practitioner should, therefore, be directed from time to time to interesting chapters in this branch of practice.

Mercurial poisoning is of relatively rare occurrence. The person who drinks a solution of perchloride of mercury with the intention of killing himself, is not likely to trouble the practitioner for many days. The lethal dose of corrosive sublimate is said to be about 0.1 grammie for an adult of average weight. Subacute poisoning as a result of the irrigation of the uterine cavity with a mercurial solution is far less common than formerly. Chronic poisoning too has become less frequent. On the other hand, chronic poisoning is still met among those engaged in making thermometers. In many cases the poisoning is due to carelessness and ignorance of the workers. The proprietors of the work-rooms in Great Britain are required to provide safeguards, but in some instances these precautionary measures are ineffective and in others the men fail to employ them. In the United States the conditions are said to be deplorable in some of the factories. Dr. W. Jacobsohn has recently described the processes of thermometer manufacture in a number of work-shops in New York and shows how the regulations of the Division of Industrial Hygiene of the Department of Public Health are defied both by the proprietors and by the employees.¹ In one factory he found all the windows closed and the air heavily charged with mercury vapour. Clinical thermometers are made from capillary glass tubing cut in lengths of not less than 10 cm.. Close to the one end a small dilation of the bore is blown after the tubing has been heated in the flame. This is technically known as the blister. Then the bulb is blown at the extreme end. The

¹ *The Journal of Industrial Hygiene*, September, 1920.

next stage is to fill the bulb with mercury. For this purpose the mercury is heated in a Bunsen burner flame. The instrument is then tested against a standard thermometer. The tops are next sealed, the blisters contracted, the heads rounded off and the stems engraved. During the process of filling the bulbs he found that no precautions were taken to prevent the volatilized metal from escaping into the air of the room. Some hoods had been provided, but these had not been adjusted in such a manner that the mercury vapour would be sucked up and discharged into the outer air. There was mercury on the benches, mercury on the floor, in cracks and crevices. The atmosphere was hot and moist. In consequence some of the spilled mercury volatilized and was inhaled. The gas-air flames were bright as well as hot. This affected the eyes of the workers. In addition the fumes of the hydrofluoric acid used during the process of etching the glass caused irritation of the conjunctivæ and respiratory passages. Some of the gas pipes were leaking. To complete the picture of faulty hygiene, there was no hot water supply for washing purposes and no proper place for hanging out-door clothes, away from the dust and vapours of the shop. In spite of these extremely bad conditions, one man had worked at the shop for over twenty years and had escaped obvious signs of poisoning until a year previously. The first symptoms noted were tremors and rigors, pain in the gums and occasional dizziness. Careful examination of this man disclosed a mercurial stomatitis, some anaemia, tremors of the tongue, hands and feet and some fever. The kidneys were affected. Mercury was found in the urine. In other cases the symptoms persisted for some years after the patients had been removed from the pernicious environment. Dr. Jacobsohn failed to discover any mercury in the urine of one patient who had been unable to work for two years.

It is recognized that the trade is not necessarily an unhealthy one. The rooms where the bulbs are filled need not be hot. Fume chambers with glass windows can be employed, so that all the vapour is removed to the outer air. The benches can be constructed to collect spilled mercury and stops can be affixed to them to prevent the metal from reaching the floor. Dressing rooms can be provided, where the workers can leave their out-door clothes during working time. Washable clothes should be worn and these should be washed once a week. The workers should be required to wash their hands and faces in hot water before going to meals. In this way mercurial poisoning in thermometer makers can be prevented.

LEUCOPLAKIA.

Leucoplakia was formerly described as a hypertrophy of the papillæ and thickening of the epidermis of the tongue, the result of a chronic irritant, such as smoking, syphilis, etc.. The occurrence of the same process on the buccal mucous membrane and on the mucous lining of the oesophagus did not induce pathologists to reconsider its nature. Within the last ten years the same condition has been observed in various organs. Leucoplakia has been found on many occasions in the urinary tract, including the renal pelvis. In this situation the pearly, opaque,

firm, white plaques have been found to consist of stratified squamous epithelium with much keratinization of the surface layers. The majority of observers describe an irregular, undulating epithelial surface. In the early stages, when the area presents only a whitish patch, proliferation of the mucosa is seen. Leucoplakia of the renal pelvis is associated with renal calculus or nephritis, just as leucoplakia of the tongue is associated with heavy smoking and syphilis, or leucoplakia of the oesophagus with heavy drinking. Dr. De Wayne G. Richey has made a study of a typical case of leucoplakia of the pelvis of the kidney and has arrived at the conclusion that the process must be regarded as a metaplasia of the lining membrane of the renal pelvis.¹ He points out that the transformation from transitional to stratified squamous epithelium falls within the definition which Orth has offered for metaplasia. It is supposed that the conversion occurs in cells which are not completely differentiated. In his own case the kidney has been the site of inflammatory changes of a very extensive kind. The epithelium had undergone destruction, the basement membrane had disappeared and granulation tissue had gradually replaced the lost structures. He concludes that the normal biological characters of the surface epithelium must have become fundamentally altered during the progress of these changes. Why the growing cells should become transformed into stratified squamous epithelium and why the process of surface keratinization should take place, neither he nor anyone else can explain. That this reaction is not the result of mere prolonged irritation or traumatism is proved by the fact that leucoplakia is far less common than inflammatory or mechanical changes in the renal pelvis. Dr. Richey refers to the recognized fact that leucoplakia appears to be a precursor of carcinoma. Ribbert's theory of cancer as an anaplastic process is not incompatible with this view, although Ribbert has opposed the theory of metaplasia as enunciated by Orth. If undifferentiated, growing epithelial cells can assume morphological and functional qualities foreign to their ancestors, it is conceivable that under a more intense chemical or physical stimulation, similar cells could take on a limitless growth with complete loss of all functional activity.

Naval and Military.

APPOINTMENTS.

The following notices have appeared in the *Commonwealth of Australia Gazette*, No. 94, of November 4, 1920:

Australian Imperial Force.

APPOINTMENTS TERMINATED.

Second Military District.

Captain G. C. Wellisch, 21st September, 1920.

Third Military District.

Lieutenant-Colonel J. K. Adey, O.B.E., 13th July, 1919.

Major P. G. Dane, 30th August, 1916.

Major A. P. Drummond, 22nd August, 1919.

Major M. Yullie, 6th September, 1920.

Major C. R. Merrillees, 17th September, 1920.

Captain H. S. Bush, 14th August, 1919.

Captain J. L. Diggle, 22nd September, 1920.

¹ *The Journal of Laboratory and Clinical Medicine*, July, 1920.

Abstracts from Current Medical Literature.

THERAPEUTICS.

(150) The Effects of Atropine on Gastric Functions.

W. A. Bastedo (*Amer. Journ. of Med. Sciences*, January, 1920) has collected in a critical review the results of various investigations which have been made in the pharmacological action of certain drugs employed to produce alterations of function in the human stomach. The action of atropine on certain organs of the body with regard to motor and secretory functions is so marked that it has long been assumed to produce similar effects on the stomach. Observations in human subjects have been made by Crohn, who used the fractional method of gastric analysis to ascertain the effects of this drug on gastric secretion. In cases of hyperacidity with normal secretion period a dose of 1^{1/2} mg. of atropine sulphate injected hypodermically three quarters of an hour after a meal had no effect on motility and caused a rapid rise in acidity towards the end of gastric digestion. When administered by mouth in doses sufficient to give signs of belladonna poisoning a similar result was observed. In a control case with continuous secretion a highly acid gastric juice persisted long after all food had left the stomach. It was found that atropine failed to lessen digestive secretion in hyperacidity and in cases exhibiting continuous secretion it had no inhibitory effect except after the digestive period. Further observations have been made upon the effect of atropine in controlling the motor functions of the stomach. The drug is frequently employed with the object of overcoming tetanic spasm at the cardia, at the pylorus or at the site of an hour-glass constriction. Numerous observers have found that atropine in relatively large doses has been capable of overcoming tetanic spasm of the cardia and of the pylorus without interfering with the normal action of peristalsis. It has therefore been surmised by Cushny that abnormal contractions, such as a pylorospasm, arise from some mechanism distinct from that which presides over ordinary peristalsis. Atropine in large doses appears to be capable of affecting the motor functions of the stomach in two ways: (i.) The abolition of tone in the whole stomach wall, including the orificial sphincters by action on the vagal myoneuronal junctions. (ii.) The abolition of abnormal spasmodic contractions as in pylorospasm, this effect probably not being dependent upon any action on the vagus terminals. It is concluded that in hyperacidity atropine has no useful effects in any dosage; in continuous hypersecretion it may check secretion after the digestive period, but only if administered in maximal doses. In pylorospasm the drug may produce beneficial effects if maximal doses be exhibited.

(151) Normal Horse Serum in the Treatment of Sepsis.

The application of normal horse serum inoculation to the treatment of sepsis is discussed by E. Emrys-Rolerts (*Journ. of Royal Army Med. Corps*, April, 1920). Several cases are reported in which beneficial results followed massive injections of the serum in patients suffering from wound sepsis. The method of procedure described was as follows. If the patient were at the time receiving spaced doses of antitetanic serum, no desensitizing dose was given. In all other cases a preliminary desensitizing dose of 1 c.c.m. was injected intradermally, followed after two hours by a subcutaneous or intramuscular injection of 50 c.c.m. If improvement followed, doses of 100 c.c.m. or 150 c.c.m. were administered on succeeding days, four or five inoculations being given in all. It was found that in cases of wound infection uncomplicated by pocketing or sequestrum formation the results were consistently satisfactory. Local improvement in the wounds was noted together with marked amelioration in the general condition of the patient. The author advances the hypothesis that the good results observed following the administration of serum are essentially due to the introduction of protein. It is maintained that the amount of complement in the circulating blood may be increased and the suggestion is put forward that in cases of severe sepsis which are apparently failing to progress satisfactorily, the condition of affairs is due rather to a deficiency of complement than to the inability of the tissues to elaborate antibodies. The exhibition of normal horse serum appeared also to be of definite value in preventing the "lighting up" of grave sepsis in cases of latent sepsis, after re-amputations and similar operative performances.

(152) Intramuscular Injections of Ether in Pertussis.

Recent work of various French clinicians in the treatment of whooping cough by intramuscular injections of ether is reviewed by L. Cheinisse (*La Presse Médicale*, July 31, 1920). This method of treatment appears to have been introduced in France in 1914, but owing to the war received little attention from clinicians. Favourable results have since been reported by various authors. It is recommended that a dose of 1 c.c.m. should be given in the case of children up to seven to eight months old; for older children and adults 2 c.c.m. repeated every two days. The drug is injected deep into the buttock with the usual aseptic precautions. After a single injection it is claimed that vomiting is usually arrested and the fits of coughing are very greatly diminished in number and severity. After three injections the improvement is usually very decided, the coughing fits become abortive and the spasms cut short, with diminution of inspiratory stridor and decreased amount of sputum. It appears that the beneficial results following this treat-

ment are not absolutely invariable. In certain instances the fits of coughing are not so readily controlled. A certain amount of pain may also follow the injections. Some writers have contended that apart from its antispasmodic action the ether has a definite effect in combating infection. In considering the therapeutic indications it is pointed out that true whooping cough must be differentiated from attacks of spasmodic cough with stridor, not infrequently encountered in children suffering from naso-pharyngeal adenopathy. The efficacy of ether in cases exhibiting broncho-pulmonary complications is questioned. It is maintained by some that in such conditions the stimulating effect of the ether is of definite value apart from its antispasmodic action.

(153) Rectal Administration of Glucose.

Kenneth H. Tallerman (*Quarterly Journ. Med.*, July, 1920) reports a series of experiments in the human subject to investigate the rectal absorption of glucose, which has long been a matter of controversy owing to the doubts which have existed of the power of the rectum to absorb this and other substances. The object of the experiments was to detect any absorption which might take place by analysis of the blood. A direct measurement was made of the rise of blood sugar after an injection of glucose per rectum. Solid glucose (60 grm.) was dissolved and made up to 180 c.c.m. with normal saline solution and the solution injected slowly as in ordinary rectal feeding. A sample of blood was taken from the patient before the injection and at set intervals of half an hour afterwards, the sugar content of the blood being estimated in each sample. The glucose injected per rectum was found to be slowly absorbed, the blood sugar rising to a maximum in a period of about 80 minutes, settling down to normal again in about four hours. The average rise of blood sugar is stated to have been 0.03%. The maximum rise in the respiratory quotient takes place at approximately the same time as the blood sugar is found to reach a maximum. It is, therefore, apparent that the administration of glucose per rectum in nutrient enemata is followed by definite absorption into the blood stream and is a rational therapeutic procedure.

UROLOGY.

(154) The Ureter in Surgical Conditions of the Bladder.

W. E. Lower (*Journ. Amer. Med. Assoc.*, September 11, 1920) discusses the best methods of dealing with the ureter in surgical conditions of the bladder when the orifices of the ureter are involved. He calls attention to the well-known fact that normally the ureter traverses the bladder wall obliquely, passing for some distance within the muscular coat. The ureter itself is provided with a mucous lining, a muscular coat and a fibrous con-

nective tissue sheath. Regurgitation and the upward extension of infection are prevented by the mechanical closure of the implanted portion of the ureter. The result of the direct transplantation of a ureter into another portion of the bladder wall after partial excision, has invariably been a dilation of the tube, backword flow of urine to the kidney and fatal infection. Lower points out that oblique transplantation carried out in a manner necessary for the proper discharge of the function of the ureter is a difficult and time-robbing procedure. He has devised a method of dealing with the ureter in cases where a neoplasm involves the vesical end of the ureter and excision can be completed in the course of a partial resection. An elliptical incision is made, including a sufficient area of bladder wall to insure a complete removal of the growth. It is, as a rule, possible to limit the sacrifice of ureter in these cases to 1.5 cm. or less. Sufficient length of ureter is retained within the bladder wall after the resection. The wound is closed with interrupted fine catgut sutures adjusted without tension. The urine trickles through the spaces between the sutures into the bladder. A mucous membrane soon forms and after a short time the new ureteral opening is re-established at a slightly higher level than that of the opposite side. The author also deals with the disposition of the ureters in the event of the total extirpation of the bladder. He uses a modification of Coffey's method of transplantation into the rectum or sigmoid, as near as possible to the bladder. The wall of the intestine is incised down to but not through the mucous membrane and the divided ureter is laid longitudinally in this incision, traversing the mucous membrane at a considerable distance from the point of entry into the intestinal wall. He transplants first one ureter and at the second stage the opposite ureter. He emphasizes the importance of ascertaining the patency and efficiency of the first transplanted ureter before the second stage is attacked. After both have been transplanted and it has been ascertained that the urine is flowing without obstruction into the bowel, the bladder is removed.

(155) Prostatectomy.

Victor Blum demonstrates very clearly the grave disadvantages of conservative treatment by catheterization for hypertrophy of the prostate (*Urolog. and Cutan. Review*, August, 1920). He argues that at best this procedure is palliative and that in the majority of cases more radical treatment becomes necessary at a later stage, when the extension of the hypertrophy and the advent of complications have increased the risk of operative procedures. Notwithstanding the limitation of usefulness of this method of treatment, the immediate mortality is greater than that of prostatectomy. He therefore teaches that treatment of prostatic hypertrophy by catheter is unjustified. In regard to prostatectomy he refers to Freyer's opinion that every

patient with hypertrophy of the prostate, no matter what age or how severely infected he may be, should be subjected to operation. Blum admits that Freyer's statistics appear to justify his radical procedure. He advocates prostatectomy subject to certain conditions. He is prepared to operate even on very old people, provided that the other conditions permit the operation. To him, the severest forms of general cachexia, including subæmæc and uræmæ conditions, diabetic coma, etc., constitute an absolute contra-indication to operation. Tuberculosis and carcinoma of internal organs are also contra-indications. In the presence of arterio-sclerosis, the signs of cardiac disturbance must be relieved before the operation is undertaken. Hypertension, however, is not a bar to operation; the blood pressure in these patients is frequently reduced after the operation. If local anaesthesia is employed, chronic bronchitis and emphysema, as well as certain cardiac affections, can be ignored. He recommends the application of the modern renal function tests for the purpose of ascertaining whether the damage in the renal tissue is so severe as to render the risk of the operation too great. In dealing with the question of the condition of the bladder, Blum holds that when hypertrophy of the prostate is complicated by calculus, tumour, diverticulum, cystitis or chronic pyelonephritis, operation is urgently demanded. When there is severe bladder infection or marked renal insufficiency, the risks may be reduced by performing the two-stage operation. He states that the emergency prostatectomy in severe haemorrhage with urinary obstruction should be avoided if possible, as the results are less favourable than after preliminary preparation by bladder drainage. He differs materially from Freyer in stating that prostatectomy is not justified in the first stage of hypertrophy before signs of retention are manifest. He prefers the suprapubic operation.

(156) Chronic Urethritis.

R. Rosen discusses the importance of complete and careful examination in all cases of chronic urethritis (*Urolog. and Cutan. Review*, August, 1920). After referring to the fact that other organisms are frequently associated with gonococcus in chronic urethritis and to the further fact that urethritis may occur as an aseptic condition, he states most emphatically that gonorrhœal urethritis cannot be differentiated from the non-specific varieties except by microscopical examination. In forming the diagnosis the procedure is as follows. Firstly, he ascertains the date of exposure to infection and the date of the appearance of a discharge. In the next place, he prepares a film from the discharge if any be present and examines this film after staining. In the next place, he makes an exhaustive examination of three or four samples of urine. The patient is examined *per rectum* and the prostate is gently palpated for roughness,

tenderness or induration. Fluid is expressed from the prostate and the slide is stained and examined for pus cells and bacteria. The seminal vesicles are palpated and as the finger is being withdrawn an attempt is made to feel Cowper's glands. When these glands are inflamed, they can be detected as nodules of about the size of a pea. The urethra is then irrigated and the bladder filled with fluid. The surface of the urethra is then examined by means of a sound for stricture, granulations or infected Littré's glands. In the last place, he makes an urethroscopic examination. He claims that this part of the examination is the most important of all. The contraindications to urethroscopy are acute inflammatory conditions and a painful and tender urethra. The urethroscope should not be passed until the surgeon has ascertained the size of the lumen of the urethra. If necessary, a meatotomy should be performed.

(157) Simple Ulcers of the Genitalia.

N. E. Aronstam discusses the diagnostic points of several simple or non-specific forms of ulceration of the genitalia (*Urolog. and Cutan. Review*, July, 1920). Herpetic ulcers form as a result of irritation of herpetic vesicles or the vesicles may rupture spontaneously. The vesicular nature of the original lesion will lead to a correct diagnosis. Bland dusting powders suffice for the treatment. Gonococcal discharge from the urethra may erode the mucous membrane of the glans or of the prepuce. Great care must be taken to distinguish between this condition and chancroid. The appearance of the ulcer is characteristic and the history should indicate the true nature of the lesion. The erosion is especially common in association with a narrow prepuce. Circumcision may be required. Erosions of the sebaceous follicles are harmless conditions. They are usually caused by staphylococci and often occur in persons working with oil or paraffin. The erosion takes the form of a crater-shaped ulcer. Traumatic abrasions due to friction are usually small and heal readily under non-irritating dusting powders. They arise occasionally in persons sweating profusely in hot weather. Diabetic ulcers are, as a rule, extensive and may assume both a serpiginous and a phagadænic appearance. These ulcers do not have the worm-eaten, undermined characters of chancroid. They are usually single. Like chancroid, healing is slow and difficult to obtain. The diagnosis depends on the examination of the urine and serological tests. Local treatment is of small avail. Lastly, the author deals with tuberculous ulcers. They occur in young subjects, although he has seen one in a patient of middle age. The diagnosis is often very difficult. The ulcer is phagadænic; it is usually deep and its margins indurated and plastic. Tubercle bacilli may be found in the pus, either by microscopical examination or by injection into guinea-pigs.

British Medical Association News.

MEDICO-POLITICAL.

A meeting of the Western Australian Branch was held at the Perth Public Hospital on August 18, 1920, Dr. A. T. White, the President, in the chair.

Dr. H. H. Field-Martell moved:

That the Western Australian Branch shall draw up a scale of fees to be in line with the minimum fees prevailing in the eastern States, such fees to cover all branches of general practice other than general surgery and specialist work;

That any general practitioner charging a lesser fee than the recognized rate shall be considered guilty of unethical conduct unless he has been granted exemption by the Branch for a period not exceeding six months, owing to special local conditions.

Dr. Field-Martell stated that the reason for the introduction of this motion was the necessity for a review of fees charged in general practice in Western Australia. He had learnt from medical practitioners in the eastern States that they had advanced their fees. Medical practitioners were affected equally with other members of the community by the increased cost of living. He thought that a small committee should be appointed to consider the matter and to report to a general meeting.

Dr. T. L. Anderson seconded the motion.

Dr. W. S. Myles held that the fees charged for consultations in the practitioner's surgery should be different from those charged for visiting.

Dr. F. T. A. Lovegrove moved an amendment to the effect that a committee be formed to ascertain the fees charged in other States, in order to obtain guidance for laying down a scale of fees, including lodge fees, for their State. Dr. Lovegrove suggested that Dr. Martell be a member of the committee and that the other members be selected to represent the metropolitan area, the country and the goldfields. He stated that the committee should report to the Branch. If the Branch determined to adopt a scale of fees, there should be a six month's trial. Any penalizing clauses which might be adopted, should not become effective until the termination of the period of trial.

Dr. D. P. Clement seconded the amendment, which was carried.

The following members were appointed to the Committee: Dr. D. P. Clement, Perth. Dr. G. J. Campbell, Claremont. Dr. E. A. Officer, Perth. Dr. K. G. McKay Aberdeen. Dr. H. H. Field-Martell. Country.

Fremantle, Dr. W. S. Myles, Country.

Dr. D. P. Clement raised the question how practitioners who were not members of the British Medical Association, could be induced to accept a new scale of fees.

Dr. F. Gill thought that the time had arrived when lodge fees should be increased.

A meeting of the Western Australian Branch was held on September 15, 1920, at the Perth Public Hospital, Dr. A. T. White, the President, in the chair.

A letter was read from the Health Inspectors' Association, asking the Western Australian Branch of the British Medical Association to appoint two delegates to attend a congress of health inspectors. It was resolved that Dr. W. P. Seed and Dr. G. W. Barber, C.B., C.M.G., D.S.O., be asked to attend the congress.

A letter was read from the Secretary of the Select Parliamentary Committee appointed to inquire into the proposal to introduce legislation for the early closing of chemists' shops.

Dr. H. H. Field-Martell moved that the Branch support the chemists in their endeavour to introduce early closing. The motion was seconded by Dr. J. J. Holland and was carried. It was resolved that Dr. Holland give evidence before the Select Parliamentary Committee.

A discussion took place on the revised scheme of the War Patriotic Fund Committee, under which it was proposed to work.

An extraordinary general meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth

Street, Sydney, on October 29, 1920, Dr. C. Bickerton Blackburn, O.B.E., the President, in the chair.

Dr. W. H. Crago moved an amendment of the Memorandum of Association of the Company (British Medical Association, New South Wales Branch) to enable the Company to raise money by debentures at 6%. He pointed out that they had been considering the question of purchasing land and erecting a new building, but had found that it was impossible to obtain the necessary money at the rate limited by Clause 4 of the Memorandum, namely, 5%. The matter would have to be determined by the Supreme Court. They had approached the Attorney-General and had asked for power to increase the rate to 7%. The Attorney-General, however, had stated that he was prepared to recommend the increase to 6%. He therefore moved on behalf of the Council in his capacity as Honorary Treasurer:

That the Memorandum of Association of the Company be altered as follows, viz.:

In Clause 4 by substituting the words "six pounds" for the words or figures £5.

Dr. R. Gordon Craig seconded the motion, which was carried.

Dr. W. H. Crago moved on behalf of the Council:

That the resolution of the Federal Committee be approved and that the quota required from the New South Wales Branch be paid out of the funds of the Branch.

He explained that the Federal Committee at its meeting held in Brisbane on August 24, 1920, had resolved to ask the Branches to provide the necessary money to send a delegate to England to attend a conference of representatives of the overseas Branches with the Council. The Representative Body had resolved to alter the constitution of the Association to enable it to become in part a federation of medical bodies. The conference had been summoned for the purpose of considering what amendments of the articles and by-laws would be necessary to give effect to this proposal (see *The Medical Journal of Australia*, September 11, 1920, page 252). Dr. Crago pointed out that it was obvious that somebody thoroughly versed in the matters involved should be selected for this purpose. He had been informed that the Federal Committee expressed a strong opinion concerning the selection of a particular representative. He asked the members to approve of the principle of expending money for the purpose, so that when the Federal Committee made its final arrangements, the Branch would be prepared to do what was required of it.

Dr. R. Gordon Craig seconded the motion, which was carried.

A special meeting of the Victorian Branch of the British Medical Association and of the Medical Society of Victoria was held on October 28, 1920, at the Medical Society Hall, East Melbourne, Mr. G. A. Syme, the President, in the chair.

The President explained that it was competent for a majority of members present at a special meeting of the Branch duly summoned to consider a proposed alteration of the rules to rescind or alter any rule or rules, provided that the altered rule or rules were in conformity with the constitution of the British Medical Association. The question of the revision of the rules had been under consideration for some time by the Council. The fact that the Representative Body had recently resolved to raise the subscription of members outside the United Kingdom from January 1, 1921, rendered an immediate consideration of Rule 26 imperative. The present subscription for members of the British Medical Association outside the United Kingdom was £1 5s. per annum, of which 4s. was retained as capitation grant and one guinea was remitted to London. The Treasurer of the Association was asking that £1 18s. per member should be forwarded to London. This amount, together with the 4s. grant retained for Branch purposes, brought the subscription up to two guineas.

The President read the various items of increased expenditure from the Supplement of the *British Medical Journal* of June 5, 1920. This increased expenditure had led the Representative Body to raise the subscription. Mr. Syme remarked that under the existing conditions it was obviously impossible for the Victorian Branch to pay the amount demanded. Rule 26 was immediately affected by this development. He stated that the time was ripe for a revision of the rules as a whole.

The Council had received from the Ballarat Division a protest against the increased subscription. The feeling of the Council was that as the present remittance of one guinea per member more than defrayed the cost of the *British Medical Journal*, representations should be made against the extra 1s. now demanded.

Dr. Rosenberg moved on behalf of the Council that the words "Melbourne and" be deleted from Rule 1. This was carried and the rule as amended read:

The Branch shall be called the Victorian Branch of the British Medical Association.

Dr. Rosenberg moved that the following addition be made to the objects of the Branch as set out in Rule 2:

(h) To hold periodical meetings of members of the Association.

The motion was carried.

Dr. Rosenberg moved the deletion of Rule 3 and the substitution therefor of the following rule:

The Council may elect as an associate member any ordinary member of any other Branch and may elect as a complimentary member any qualified medical practitioner or person distinguished in science resident within the area of the Branch, but not eligible for ordinary membership of the Association. Such members may have such privileges as the Council may think desirable, other than that of voting.

The new rule was adopted.

Dr. Rosenberg moved that Rule 4 be deleted and a new rule be substituted therefor:

The Council shall consist of fourteen members elected by the general body of members, four trustees for the time being of the Medical Society of Victoria, the Director for Victoria of the Australasian Medical Publishing Company and those members elected by the Divisions.

Mr. Syme considered this rule to be most important. It was in effect a reversion to the procedure obtaining in the Victorian Branch before its amalgamation with the Medical Society of Victoria. The motion was carried unanimously.

Dr. Rosenberg moved an additional rule to Rule 4 as follows:

The Council shall have the power to co-opt three additional members to the Council.

The motion was carried.

Dr. Rosenberg moved a further new rule as follows:

At the first meeting of the Council it shall elect from among its members a President, two Vice-Presidents, an Honorary Treasurer, an Honorary Secretary and a Librarian.

He pointed out that the effect of this rule would be to place the election of the office-bearers of the Council in the hands of the Council itself. Formerly these officers were chosen by a ballot of the members of the Branch. The new rule provided for one Librarian instead of two.

Dr. S. S. Argyle strongly advocated that a chairman of committees should be included among the office-bearers enumerated in the rule. It was necessary to have a permanent officer in this capacity. At present the President was *ex officio* a member of all committees, but his tenure of office usually expired at the end of twelve months. The office of chairman of committees was maintained by the majority of legislative bodies and was designed to insure continuity of policy. He moved as an amendment:

That a chairman of committees be added to the list of office-bearers.

The amendment was seconded by Dr. J. W. Dunbar Hooper and was carried. The motion as amended was also carried.

Dr. Rosenberg next moved a new rule in substitution for Rule 5:

The members of the Council other than the representatives of Divisions, the Trustees of the Medical Society of Victoria and the Director for Victoria of the Australasian Medical Publishing Company shall be elected annually by ballot of members at the annual meeting of the Branch.

Nomination papers shall be sent to all members at least ten days prior to the monthly meeting in November and such nomination papers shall be returned to the Secretary on or before such monthly meeting. The Secretary shall within 48 hours of that meeting write to all nominated candidates or their attorneys for their

consent to such nomination. If such nomination is accepted or if no reply is received within a further seven days, the names of all persons so nominated shall be placed on the ballot paper. A ballot paper shall be sent to each member, together with a copy of the notice paper summoning the annual general meeting at least one week before the annual general meeting.

This ballot paper shall be accompanied by a form of declaration and two envelopes marked respectively "Ballot Paper" and "Secretary, British Medical Association, East Melbourne." The ballot paper must be sealed in the envelope provided and enclosed in the envelope addressed to the Secretary, together with the declaration duly signed. This must be returned so as to reach the Secretary not later than 8 o'clock p.m. on the day preceding the annual general meeting. After that hour the two scrutineers, who shall have been appointed at the November monthly meeting, shall open the outer envelope. If the declaration shall have been duly signed, the envelope containing the ballot paper shall be placed in the ballot box. After all the declarations have been examined, the scrutineers shall ascertain the result of the election and report to the annual general meeting.

The scrutineers shall be selected from members who have not been nominated for election to the Council and they shall be empowered to appoint assistants to help them in the conduct of the ballot.

The amended rule was adopted.

In moving a new rule as set out below, Dr. Rosenberg advocated its adoption on the ground that by this means the Council would be brought more closely in touch with the component parts of the Branch. It would facilitate the work of the Council. It had been found during the recent negotiations with the friendly society lodges that the presence of the honorary secretaries of the Divisions was of great assistance on account of their intimate knowledge of the affairs of their districts.

The Branch shall be formed into separate local bodies called Divisions. The Council shall declare from time to time what shall be the local area of each Division and shall have power from time to time to amalgamate, subdivide and modify divisions for the purpose of the annual election of the Council or otherwise, provided that one calendar month's notice in all cases shall be given to any division in which any change is proposed. Such notice shall be forwarded in writing to the Chairman and Secretary of the Division.

In answer to a question by Dr. S. S. Argyle, the President said that the organization provided by the proposed new rule was completely in accord with the constitution of the British Medical Association. According to the ruling of the "central body" the Division was the unit and the Divisions were amalgamated into Branches.¹

The rule was adopted, as was the following:

Each Division or divisional group as determined by the Council shall elect one representative on the Council for the ensuing year on or before the first of October in each year.

Dr. Rosenberg moved the deletion of Rule 6 and the substitution of the following new rule:

Extraordinary vacancies on the Council may be filled by the remaining members of the Council.

Should any Division fail to elect a member of the Council, the Council at its first meeting may elect a representative of that Division, provided that he is a member of the aforesaid Division.

The motion was carried.

The following new rule was also adopted:

Every member whose address is registered for the time being in the books of the Association as at a

¹ It is unfortunate that the Victorian Branch should have adopted the name "Division" for local parts of the Branch. According to Article 13 (2) of the British Medical Association the area of each Division which Mr. Syme pointed out, is the unit for government purposes, is fixed by the Council of the Association. Each Division having not less than fifty members has the right of separate representation in the Representative Body—By-law 33 (2). In some instances the Divisions and the Branches are coincident. This is the case in all the Australian Branches of the British Medical Association. In other words the Victorian Branch is itself a Division in the sense in which this term is employed in the Articles and By-laws of the Association.

place situate within the area of any Division shall *ipso facto* be an ordinary member of that Division and of no other.

Rule 7 was deleted.

It was resolved to amend Rule 11 to read:

Any legally qualified medical practitioner not disqualified by any By-law of the Association, who shall be recommended as eligible by any three members, may be elected an ordinary member of the Branch by a majority of the members present at a meeting of the Branch-Council, provided that he has made application on the prescribed form to become a member.

The following new rule was adopted:

An ordinary member admitted on or after the first day of July in any year shall be liable only for half his current subscription for that year.

Dr. Rosenberg explained that Rule 12, relating to expulsion of members, had been recast. He submitted the new rule for adoption:

The Council on the representation of any two members of the Branch and at a special meeting of the Council convened at not less than one month's notice, after due inquiry of which twenty-eight days' notice in writing shall have been given to the member specifying a time and place at which he may be heard in his defence, shall have power to expel from membership of the Association any ordinary member of the Branch on the ground that his conduct is deemed by the Council to be detrimental to the honour or to the interests of the medical profession or Association or is calculated to bring the profession into disrepute or on the ground that the member has wilfully and persistently refused to comply with the regulations of the Association or of the Branch of which he may be a member.

Such resolution of the Council must be carried by a majority of three-fourths of those present and voting at such special meeting, subject to confirmation by three-fourths of the members present at the next general meeting.

Such member shall thereupon cease to be a member and shall not be eligible for re-election.

An expelled member shall, notwithstanding that he has ceased to be a member, be liable to pay all sums due from him to the Branch at the time of his expulsion.

Dr. J. W. Dunbar Hooper expressed the opinion that the words "in writing" should be inserted after the words "on the representation" in the first line. Dr. A. V. M. Anderson moved an amendment to this effect, which was seconded by Dr. Dunbar Hooper and carried. The motion as amended was carried.

The following new rule was also adopted:

No member whose conduct is under investigation, or is the subject of inquiry by the Council, shall be capable of effectively resigning his membership of the Branch, nor shall his membership be terminated by default in payment of his subscription until the investigation or inquiry is completed and the decision thereunder is made known. An inquiry or investigation shall for the purpose of this clause be deemed to commence at the time when the matter of such investigation or inquiry is first brought officially under the notice of the Council.

Rule 13 was amended to read as follows:

Any meetings of the Branch or of its Council shall be held conjointly with meetings of the Medical Society of Victoria or of its Committee and any nomination, election, ballot, referendum or other action shall be held or taken conjointly for purposes of the Branch and the Society or for purposes of the Council of the Branch and of the Committee of the Society.

Rule 14, dealing with the definition of general meetings of the Branch, was deleted. Rule 15 was amended to read as follows:

The annual meeting shall be held on the first Wednesday in December at eight p.m. at such place in Melbourne as the Council may appoint. The business shall include the annual reports of the Council and of the Librarian, the election of office-bearers for the ensuing

year, an address by the retiring President and such other business as the Council may determine.

Rule 20 was amended so as to enable any two of the following to have power to sign cheques: the President, the Honorary Treasurer and the Honorary Secretary.

Rule 21, providing for an assistant Treasurer, was deleted. Rule 24 was amended to read as follows:

The Council shall meet in general on the second Thursday and last Wednesday in each month at such time and place in Melbourne as the Council may determine, provided that where five Thursdays occur in any month the meeting shall be held on the third Thursday instead of the second Thursday. The Council may vary the day for any of its meetings. So far as may be practicable all the business proposed to be made the subject of consideration at any meeting of the Branch shall be submitted to the Council meeting immediately preceding. The Council shall have the general executive administration of the Branch. It shall furnish a general report of the state of the Branch at the annual meeting. In addition to its regular meetings, the Council may be called together at any time at the instance of the President or of any three of its members.

Dr. C. H. Mollison moved the deletion of the sum "f1 5s." and of the words in parentheses in Rule 26, and the substitution thereof of the sum "f2 2s." The rule read as follows:

Every ordinary member shall pay a subscription to the Branch of f1 5s. (being f1 1s. for the British Medical Association and the remainder for Branch purposes), which shall entitle him to receive the Journal of the Association for the current year only. The subscription shall date and be considered due in advance of the first of January in each year.

Mr. Mollison explained that an extra 17s. had to be provided for the increased expenditure of the central organization in London and 2s. had also to be provided for the Federal Committee. The Branch was thus faced with an additional expenditure of 19s. per member for the new financial year. He estimated that it would be necessary to ask a subscription of four guineas from the town members, f3 13s. 6d. for country members and f2 12s. 6d. for junior members. Of these amounts two guineas, one and a half guineas and a half of a guinea respectively would be allocated to the Medical Society of Victoria. With regard to the increased subscription to be paid to the British Medical Association, Dr. Mollison said that there was no alternative unless it were contemplated that the Branch should break away from the parent Association. The Council had already decided to send a letter of protest and to ask for a rebate, or, as it was termed, a "supplementary grant." He did not think that they should be called upon to pay more than the extra cost of the *British Medical Journal*. That was amply covered by the present remittance. As long as the Branch remained a part of the British Medical Association, they were bound to pay the subscription, although they might protest.

Mr. Syme expressed the opinion that the application for a supplementary grant would be favourably considered by the Council in London.

Dr. Mollison's motion was carried as was the necessary amendment of the Rule 32 of the Medical Society of Victoria.

Some minor consequential amendments were made in Rule 27.

Dr. Rosenberg moved:

That the Council be empowered to appoint a subcommittee to incorporate in the rules the foregoing amendments as carried by this meeting, to re-arrange the rules and to make any amendments as may be found necessary.

The motion was carried.

The undermentioned have been nominated for election as members of the New South Wales Branch:—

Ernest Frederick Fisher, Esq., M.B., 1920 (Univ. Sydney), State Hospital, Lidcombe.

John Araulen Kennedy, Esq., M.B., Ch.M., 1919 (Univ. Sydney), 423 Marrickville Road, Dulwich Hill.

Correspondence.**ANÆSTHETICS ADMINISTERED BY DENTISTS.**

Sir: In your issue of September 25 I criticized Dr. W. S. Ziele, a Sydney dentist, for making the following statement: "It is a most significant fact that no death has ever occurred in New South Wales in the use by dentists of ethyl chloride." This I characterized as a careless and unverified statement and I drew attention to the fact that a dentist practising in Oxford Street, Sydney, had had a death during administration of ethyl chloride. I concluded by saying that the date could, no doubt, be easily found from the Coroner's records.

Next followed in your issue of October 30 a letter from Dr. Ziele in reply, saying that in response to an application to the Department of Justice he had received a letter signed by the Under-Secretary and dated October 18, 1920, containing the following statement: "There is no record at the City Coroner's Office of a death under anaesthetic administered by a dentist."

As I knew that the case had occurred, this letter carried no weight; it only showed that it had either been unrecorded or unregarded. So I paid a visit to the Coroner's Office and within ten minutes had the following information: Annie Anderson, aged 28, married, died in the dentist's chair while having teeth extracted under anaesthesia by "narcotile" (ethyl chloride) in the rooms of the Federal Dental Company, 12A Oxford Street, Sydney, February 2, 1905. Dr. J. C. Windeyer, then of 28 College Street, now of 235 Macquarie Street, was called in and pronounced life extinct. A post mortem examination was made on February 5, 1920, by Dr. A. A. Palmer, which discovered no sign of organic disease and the death was recorded as due to "cardiorespiratory failure during administration of 'narcotile'."

Dr. Ziele has, therefore, been relying on material that will not stand examination.

Yours, etc.,

C. E. CORLETTÉ.

Sydney,

November 4, 1920.

THE TREATMENT OF EXOPHTHALMIC GOITRE.

Sir: In a letter of mine dated October 14 appearing on page 426 of last number of *Journal*, I wish to correct a paragraph which includes more than should be included as a quotation from Dr. Dunhill's article in the *British Journal of Surgery*.

The quotation stops at the words "in a small number of cases."

The further remarks: "The necessity for the removal of the whole of one lobe cleanly"—not "clearly"—and so on are mine and not from the above-mentioned article.

Yours, etc.,

FRANK L. DAVIES.

148 High Street, Malvern, Victoria,

November 1, 1920.

[Dr. Davies in his original manuscript gives no indication of the end of the quotation and does not commence a new paragraph on resuming his own remarks.

If correspondents would use a typewriter, they would escape the risk of the confusion between a very doubtfully formed "n" and an "r."—Ed.]

THE TREATMENT OF POST-MORBILLIC BRONCHOPNEUMONIA.

Sir: I wish to bring under your notice several cases of severe broncho-pneumonia following measles.

All cases were in desperate straits of cardiac embarrassment and respiratory failure. They were placed on brandy and a mixture of strychnine and strophanthus by the mouth and wet packs. In spite of these measures no improvement was shown. These cases were children and were treated in tents in railway camps. I then gave camphor in oil every six hours. The improvement was evident at once, both in pulse and respiration. All cases recovered and convalescence

was rapid. The preparation used was Parke, Davis & Co.'s camphor in oil (1 mill = 2 grm. camphor).

There is nothing new about this treatment; I well remember ten years ago using domestic camphorated oil in sudden collapse with most happy results. The results observed from the exhibition of the camphor in oil were increased diaphoresis, marked sedative action and slowing and steadyng of the pulse in the above-mentioned cases.

Yours, etc.,

ARTHUR WATKINS.

Griffith, New South Wales,

November 2, 1920.

REGISTRATION OF SIGHT-TESTING OPTICIANS.

Sir: I regret that when writing my letter on this subject, which you kindly published in your issue of October 23, I had not seen the resolutions to which Dr. Keney now draws my attention.

May I ask you to publish the following?

In London (*vide* the *London Daily Telegraph* of December 2, 1909, abridged) memorials were signed by the late Lord Kelvin, with many other leading scientific men, members of parliament, representatives of the optical industry, etc., praying for an inquiry into the desirability of sight-testing by non-medical practitioners and suggesting that it might be found useful to institute a further examination for opticians in practical sight-testing.

The Court therefore appointed a committee of investigation composed of the Right Honourable Lord Aldenham, M.A., the Right Honourable Sir William Hart Dyke, Bart., M.A., P.G., D.L., J.P., Sir Marcus Samuel, D.L., J.P., Lieutenant-Colonel Sir Horatio D. Davies, J.C., M.G., V.D., and the late Mr. H. E. Thornthwaite, F.R.A.S., with Sir G. Faudel Philips, Bart., G.C., I.E., D.L., J.P., as Chairman, whose conclusions, based on elaborate expert evidence, were to the effect that fitting spectacles and adapting lenses to correct mechanical defects of sight is an art or profession wholly distinct from those of medicine and surgery.

Yours, etc.,

A. KNAPP,

President, Western Australian Optical Association,
25 Barrack Street, Perth,

November 2, 1920.

[Mr. Knapp is singularly unfortunate in the selection of his argument to support the movement for the registration of opticians as sight-testers. The eminent politicians and wealthy commercial magnates composing the committee referred to in Mr. Knapp's letter, evidently had sufficient discrimination to distinguish between the art of fitting spectacles and adapting lenses from the science of ascertaining the visual defects necessitating correction.—Ed.]

Captain F. A. Chaffey asked the Minister of Public Health in the Legislative Assembly of New South Wales on November 4, 1920, whether he would consider the advisability of introducing a measure to compel opticians to have their names placed on a register. He claimed that this should be done for the protection of the sight of persons residing in the State and for the protection of qualified opticians. The Minister stated that when time permitted, he intended to bring in legislation for the purpose of dealing with the matter.

THE LEAGUE OF THE RED CROSS SOCIETIES.

We learn from the July-August issue of the *Bulletin of the League of the Red Cross Societies* that the first meeting of the Medical Advisory Board was held at Geneva from July 5 to July 8, 1920. This was the first occasion on which an international committee has met to consider questions of hygiene and preventive medicine from the point of view of the institution of measures of amelioration. The subjects discussed included the campaign to combat typhus and other communicable diseases in Poland, the immediate organization of child welfare units, the continuance of propaganda work in sex education and the prevention of venereal disease, the means of cheapening the cost of manufacturing arseno-benzol drugs and of quinine, the extension

of anti-tuberculosis work and the elaboration and perfecting of sanitary surveys. The British societies were represented by Sir George Newman, Sir Walter Fletcher, Dr. A. Castellani and Colonel S. Lyle Cummings. The American delegates were Dr. Simon Flexner, Dr. Hermann M. Biggs and Dr. William H. Welch. The French delegates were Professor Emil Roux and Professor Albert Calmette. The Belgian delegates were Dr. J. Bordet and Professor Leon Bernard. The Italian societies were represented by Professor G. Bastianelli, while Professor T. H. Madsen appeared for the Danish societies and Dr. S. Takasugi for the Japanese. Sir David Henderson, the Director-General of the League, and Dr. R. P. Strong, the General Medical Director, were also present at the meetings.

Books Received.

ANESTHETICS, THEIR USES AND ADMINISTRATION. Sixth Edition, by Dudley Wilmot Buxton, M.D., B.S.; 1920. London: H. K. Lewis & Co., Ltd.; Demy 8vo., pp. 548, with 97 illustrations, including 8 plates. Price, 21s. net.
THEORY AND PRACTICE OF NURSING. by M. A. Gullan; 1920. London: H. K. Lewis & Co., Ltd.; Demy 8vo., pp. 214. Price, 16s. 6d. net.

Medical Appointments.

Dr. Donald Cameron (B.M.A.) has been appointed District Medical Officer and Public Vaccinator at Collie, Western Australia.

The appointment of Dr. John Kenny (B.M.A.) as Justice of the Peace for the Gascoyne Magisterial District of Western Australia, has been approved.

Dr. S. C. Moore (B.M.A.) has been appointed Medical Officer of Health to the Municipality of South Perth and Dr. J. E. O. Flynn to the Phillips River Road Board of Western Australia.

Dr. T. S. Greenaway (B.M.A.) has been appointed Medical Officer to the Enthetic Diseases Clinics in Hope Street and William Street, Brisbane, and to the Venereal Diseases Hospital in Brisbane. The appointments have been made under the provisions of the *Public Health Act* of Queensland.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxv.
 Hospital for Sick Children, Brisbane: Honorary Surgeon to the Ear, Nose and Throat Department.
 Ballara Hospital, near Cloncurry, Queensland: Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
NEW SOUTH WALES.	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phoenix Mutual Provident Society.
(Hon. Sec., 30-34 Elizabeth Street, Sydney.)	

Branch.	APPOINTMENTS.
VICTORIA.	All Institutes or Medical Dispensaries. Manchester Unity Independent Order of Oddfellows. Ancient Order of Foresters. Hibernian Australian Catholic Benefit Society. (Hon Sec., Medical Society Hall, East Melbourne.)
QUEENSLAND.	Grand United Order of Free Gardeners. Sons of Temperance. Order of St. Andrew. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
SOUTH AUSTRALIA.	Contract Practice Appointments at Renmark. (Hon. Sec., 3 North Terrace, Adelaide.)
WESTERN AUSTRALIA.	Contract Practice Appointments in South Australia.
NEW ZEALAND: WELLINGTON DIVISION.	All Contract Practice Appointments in Western Australia.
(Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

- Nov. 16.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
 Nov. 16.—Illawarra Suburbs Med. Assoc. (Annual).
 Nov. 17.—W. Aust. Branch, B.M.A.
 Nov. 17.—North Eastern Med. Assoc. (N.S.W.).
 Nov. 23.—N.S.W. Branch, B.M.A.; Medical Politics Committee; Organization and Science Committee.
 Nov. 23.—Vic. Branch, B.M.A.; ballot papers issued for election of office-bearers of Branch.
 Nov. 24.—Vic. Branch, B.M.A., Council.
 Nov. 25.—S. Aust. Branch, B.M.A.
 Nov. 25.—Q. Branch, B.M.A., Council.
 Nov. 26.—N.S.W. Branch, B.M.A.
 Nov. 30.—Vic. Branch, B.M.A.; ballot papers returned to Victorian Branch for election of office-bearers of Branch.
 Dec. 1.—Vic. Branch, B.M.A.; Annual General Meeting; election of office-bearers.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.
 Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.
 All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: B. 4635.)